Adult Substance Misuse Health Needs Assessment: London Borough of Bexley

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EXECUTIVE SUMMARY

Aim and scope

This needs assessment sets out a clear, integrated picture of adult (18+) drug and alcohol use in Bexley—covering people not known to services, those currently in treatment and those in recovery. It brings together prevalence and harm data, service access and outcomes, and lived and professional insights to understand where the system is working well and where there are gaps. The aim is to inform the Combatting Drugs Partnership (CDP), guide commissioning and strengthen the wider system response.

Methods

A mixed methods approach combined epidemiological analysis (prevalence modelling, treatment datasets, hospital admissions and mortality, police and criminal justice data), comparative benchmarking to London/England and Southeast London neighbours, and a corporate strand drawing on the views of 32 stakeholders, 11 service users, and 26 GPs. A rapid review of national policy and evidence provided further context. Findings were triangulated to prioritise themes supported across quantitative data, professional insights and lived experience.

National context and policy direction

Nationally, drug use has begun to rise again after a long period of decline, and drug-related deaths are at record levels, with the greatest burden among men and adults in mid-life. Cocaine-related mortality has increased sharply and potent synthetic opioids have emerged as a preparedness risk. Alcohol-specific mortality is also at a record high, disproportionately affecting men. These trends sit alongside a strong social gradient in harm, with the most deprived communities experiencing the greatest burden.

The policy direction emphasises whole system reform. Dame Carol Black's Independent Review of Drugs highlighted the erosion of prevention, treatment and recovery capacity nationally and called for sustained investment, stronger

multiagency coordination and improved pathways for people with complex needs. Building on these findings, the national 10-year drugs strategy *From Harm to Hope*, national clinical guidance (the Orange Book and NICE) and the Commissioning Quality Standard all expect earlier identification, evidence based treatment, robust harm reduction, equitable access across groups and integrated multiagency working — including a 'no wrong door' approach for people with co-occurring mental health and substance use needs

Local picture: prevalence, treatment and unmet need

Bexley's prevalence profile is mixed. Opiate and/or crack use is markedly lower than London and England, concentrated among men and peaking at ages 35–44—consistent with an ageing cohort of long-term users. Alcohol dependency, by contrast, is comparable to national estimates and distributed more broadly across ages, with higher rates among younger adults and men. Together, this suggests differing identification and engagement challenges for alcohol and drug use.

Despite this relatively stable prevalence picture, overall treatment numbers in Bexley have fallen in recent years, dropping from 992 adults in 2023 to 924 in 2025 (a 6.9% reduction), at the same time as engagement increased across London and England. The decline is driven mainly by fewer alcohol presentations: between 2023 and 2025, alcohol and alcohol-related treatment episodes fell from 519 to 453 (a 12.7% decrease), and alcohol-only cases reduced from 351 to 288 (a 17.9% decrease). This contraction in treatment comes at a time when alcohol-related harm is rising; alcohol-specific hospital admissions in Bexley have increased by 40% over seven years, with the highest rates among older adults and men. Taken together, this growing gap between harm and treatment suggests that the system is not consistently identifying and supporting adults with harmful or dependent drinking early enough, and that referral pathways into alcohol treatment may not be functioning as intended.

The treatment cohort is ageing, particularly among opiate/crack users and people in alcohol treatment. Men and LGBTQ+ people are overrepresented in Bexley's services, as seen nationally. Ethnic inequalities are evident: White British residents are overrepresented, Asian, Black and mixed groups are underrepresented, with stakeholders describing access barriers due to fear of cultural stigma. Unmet

need remains substantial: an estimated half of people with opiate/crack use needs are not in treatment (especially younger adults and those using crack only) and only about one in five dependent drinkers are engaged. Rising unmet mental health need among people in treatment—particularly men—indicates persistent gaps at the interface between mental health and substance misuse pathways.

Drug and alcohol harms

Acute drug-related harm in Bexley is comparatively low: ambulance call-outs and drug-related admissions are lower than, or similar to, neighbouring boroughs. However, alcohol presents a growing challenge. Alcohol-specific admissions have increased by around 40% over seven years, with the highest rates among older adults and men. This pattern signals missed opportunities for earlier prevention and brief intervention in community and acute settings, and it reinforces the need to strengthen proactive case-finding and alcohol care pathways.

Mortality patterns mirror these dynamics. Drug-related deaths remain among the lowest in London (small numbers limit granularity), while alcohol-related mortality shows a pronounced gender gap, with men dying at more than three times the rate of women. Social harms also reflect local risk. Bexley records one of the lowest offence rates (possession and trafficking) in Southeast London. However, drug testing on arrest has highlighted cocaine as a likely driver of acquisition crimes and domestic abuse. Vulnerabilities such as cuckooing cluster in more deprived northern wards, underlining the intersection of exploitation, deprivation and substance harm. The economic burden of alcohol alone is estimated at about £98.8 million annually, spanning health, crime, productivity and social care costs.

Identification, access and criminal justice pathways

Early identification is inconsistent across adult services. While training within CYP, mental health and criminal justice sectors has increased confidence and referrals, routine enquiry, brief advice and supported referral are less embedded across wider adult services. Professional referrals into treatment have risen overall, particularly from criminal justice, children's services and mental health, but adult social care, housing and

employment referrals remain low—suggesting a reachable opportunity to expand case-finding through workforce development and supported referral processes.

Criminal justice pathways are a strength with scope to improve continuity. Drug Testing on Arrest compliance is strong and 'second-chance' booking supports high attendance at Required Assessments.

Continuity of care from prison into community treatment has slipped noticeably in Bexley. After improving from 23.5 percent in 2020/21 to 50.0 percent in 2022/23, timely treatment pickup fell to 31.7 percent in 2024/25, while London and England continued to improve to 43.8 percent and 57.3 percent respectively. This decline is associated with short-notice prison releases, difficulties arranging prescriptions on early release, and the large number of people leaving custody with no fixed abode – affecting 44 percent of Bexley residents leaving HMP Thameside – presenting difficulties due to lack of forwarding contact details. Despite the presence of a prison link worker at HMP Thameside, only 43.0 percent of people released from HMP Thameside were seen by treatment services within 21 days, compared with 48.8 percent of those released from other prisons. Together, these issues highlight structural barriers that disrupt the transition from prison to community treatment and increase the risk of relapse and harm. Given the elevated risk at the point of release, restoring timely pick-up is a priority for harm reduction, recovery and reoffending prevention.

Treatment and recovery system

The Pier Road Project (PRP) delivers a comprehensive, evidence-based offer aligned with national guidance, including harm-reduction (needle exchange, naloxone, supervised consumption), psychosocial interventions and pharmacological treatment, family support and specialist pathways (notably for ketamine). Residential rehabilitation access has increased and exceeds national expectations. Recovery support is strengthened through partnerships with St Giles Trust, Re-Instate and the Salvation Army, and lived-experience involvement in the CDP is growing. Nonetheless, geography (access from South Bexley), daytime scheduling for some groupwork, limited inpatient COMHAD provision locally and the wider pressures of housing and employment continue to constrain engagement and sustained recovery.

Stakeholder insights

Stakeholders describe hidden populations including older adults with long-standing alcohol use who do not identify their use as problematic; younger adults with hazardous drinking patterns who do not see a need for help; and minority ethnic groups facing stigma, confidentiality concerns or language barriers. Practitioners value PRP's inclusive, 'second-chance' culture and strong links with probation and rough-sleeping services. But they also report variable confidence across the wider workforce, fragmentation at the mental health/substance interface, and housing scarcity that makes engagement and continuity fragile. The assessment therefore points to a system that is capable and collaborative, yet not consistently configured to find people early or to sustain recovery when wider vulnerabilities are present.

Recommendations (summary of actions)

Four priorities flow directly from the evidence.

First, deepen understanding of unmet need and improve access among groups at higher risk of being missed in treatment services—particularly minority ethnic communities, younger adults with alcohol dependency, older adults with chronic alcohol excess and residents in South Bexley—using targeted outreach, tailored communications and trusted community channels.

Second, widen early identification and supported referral by upskilling the broader adult workforce (ASC, housing, DWP/Jobcentre, domestic abuse and voluntary sector) in routine enquiry, brief advice and simple referral into PRP.

Third, strengthen recovery outcomes by expanding post-treatment recovery support and working jointly with housing and employment partners to remove structural barriers, with a specific focus on reducing unplanned exits among men.

Finally, consolidate multi-agency working and data-sharing—improving prison-to-community information flow, embedding COMHAD 'no wrong door' pathways, and maintaining preparedness for emerging synthetic opioid risks.

1. CONTENTS

GLOSSARY OF TERMS / ABBREVIATIONS

ASC	Adult Social Care
ATR	Alcohol Treatment Requirement
CBT	Cognitive Behavioural Therapy
CDP	Combatting Drugs Partnership
CJ(S)	Criminal Justice (System)
CM	Change motivation
COMHAD	Co-occurring Mental Health, Alcohol and Drugs
CYP	Children and young people
DRR	Drug Rehabilitation Requirement
DHSC	Department of Health and Social Care
DWP	Department of Work and Pensions
EBE	Experts by experience
ETE	Employment, training or education
ICS	Integrated Care System
JCDU	Joint Combatting Drugs Unit
NDTMS	National Drug Treatment and Monitoring System
NFA	No fixed abode
OCU	Opiate and/ or crack users
OHID	Office for Health Improvement and Disparities
ONS	Office for National Statistics
OST	Opioid Substitution Therapy
PCN	Primary Care Network

PRP	Pier Road Project
RA	Required Assessment
SEL	Southeast London
SLaM	South London and Maudsley
UKHSA	UK Health Security Agency
VAWG	Violence Against Women and Girls
VCSE	Voluntary, community and social enterprise
YE	Year Ending

1. INTRODUCTION

This report presents a comprehensive needs assessment of drug and alcohol use among adults in Bexley. Its purpose is to understand the scale and nature of substance use locally, including people who are not currently accessing support, those who are engaged with treatment and those in recovery. By examining both visible and hidden need, the assessment aims to strengthen early identification, prevention, harm reduction and the effectiveness of the wider system response.

This assessment focuses on adults aged 18 and over who use illicit drugs and/or alcohol, including those in treatment, not currently engaged with services, or in recovery, and considers wider system factors such as housing, employment, mental health and the criminal justice system that shape substance use and recovery. It does not include children and young people under 18, tobacco use and smoking cessation, or the misuse of prescription medications.

The findings will inform the work of the Bexley Combatting Drugs Partnership, support strategic planning and commissioning, and highlight areas where further research or improved data collection is required. The report brings together quantitative data, stakeholder perspectives, lived experience and national evidence to create an integrated picture of substance-related needs in Bexley.

Background

Substance misuse places a significant burden on individuals, communities and public services. Recognising the scale of this harm, the Government commissioned Dame Carol Black's Independent Review of Drugs (2019–2021) to assess national drug-related harms and recommend system-wide reforms. Part 1 highlighted resilient drug markets, over 3 million adults using drugs, and societal costs exceeding £19 billion annually[1]. Part 2 identified the erosion of prevention, treatment and recovery services due to long-term funding cuts, calling for coordinated whole-system action and sustained investment, with every £1 spent on treatment estimated to save £4 in wider costs[2].

Vulnerability to substance use and related harms arises from interacting genetic, social and environmental factors. Risks (including homelessness, unemployment, adverse childhood experiences, contact with the criminal justice system) are probabilistic rather than predetermined and can be mitigated by stable housing, early support and protective social networks[3].

In response to Dame Carol Black's findings, the Government published *From Harm to Hope* (2021)[4], a 10-year national drugs strategy focused on reducing supply, strengthening treatment and recovery, and shifting long-term demand. The strategy requires each local area to establish a multi-agency Combatting Drugs Partnership (CDP) to coordinate delivery across health, social care, criminal justice, education and the voluntary sector.

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[1] Home Office. *Review of drugs: phase one report*. London: Home Office; 2020.
[2] Home Office. *Review of drugs: phase two report*. London: Home Office; 2021.
[3] Advisory Council on the Misuse of Drugs. *Vulnerabilities and substance use*. London: ACMD; 2018.
[4] Home Office. *From harm to hope: a 10-year drugs plan to cut crime and save lives*. London: HM Government; 2021.

National practice is guided by standards and clinical guidelines such as the Commissioning Quality Standard[5], the UK clinical guidelines for drug treatment (Orange Book)[6], NICE guidance on co-occurring conditions and psychosocial interventions[7,8,9], and ACMD prevention guidelines[10]. These set out evidence-based principles for prevention, harm reduction, clinical treatment, and system-wide working. A full summary of national clinical, commissioning and prevention guidance is provided in Appendix A.

Locally, Bexley's Statement of Licensing Policy (2026–2031)[11] and the Southeast London Vital 5 Action Plan[12] provide a framework for addressing alcohol-related harm through licensing controls, early identification, intervention and system leadership. National workforce reforms aim to rebuild and professionalise the drug and alcohol treatment workforce, supporting delivery of the ambitions outlined in From Harm to Hope[13].

[5] Office for Health Improvement and Disparities (OHID). *Commissioning quality standard: alcohol and drug treatment and recovery guidance. 3 Aug 2022.* London: Department of Health and Social Care; 2022.

[6] Department of Health and Social Care (DHSC). *Drug misuse and dependence: UK guidelines on clinical management*. London: DHSC; 2017.

[7]National Institute for Health and Care Excellence. *Co-existing severe mental health and substance misuse: community health and social care services* [Internet]. London: NICE; 2016. (Clinical guideline [NG58]).

[8] National Institute for Health and Care Excellence (NICE). *Co-existing severe mental illness (psychosis) and substance misuse: assessment and management in healthcare settings* [Internet]. London: NICE; 2011. (Clinical guideline [CG120]) [cited 2026 Feb 25].

[9] National Institute for Health and Care Excellence (NICE). *Drug misuse in over 16s: psychosocial interventions* [Internet]. London: NICE; 2007. (Clinical guideline [CG51]) [cited 2026 Feb 25].

[10] Advisory Council on the Misuse of Drugs (ACMD). *Drug misuse prevention review.* Updated 18 May 2022. London: Home Office; 2022.

[11] London Borough of Bexley (LBB). *Statement of Licensing Policy: Licensing Act 2003. 07 Jan 2026–06 Jan 2031* [Internet]. London: LBB; 2026 [cited 2026 Feb 25].

[12] Southeast London Integrated Care System. *Vital 5 Alcohol Harms. 2025/26 Action Plan* [Unpublished] SEL ICS; 2025.

[13] Department of Health & Social Care (DHSC). *10-year strategic plan for the drug and alcohol treatment and recovery workforce (2024-2034)*. London: DHSC; 2024 Jul.

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Definitions

Substance misuse, as defined by NICE, refers to dependence on or regular excessive use of substances that results in physical, mental or social harm[14]. This excludes occasional or experimental adult drug use. Harmful use, as classified under ICD-11, is a pattern of substance use that causes damage to a person's physical or mental health or leads to behaviour that harms others[15]. Examples include toxic effects such as alcohol-related liver disease, behavioural harms, and risks linked to unsafe administration (e.g., blood-borne viruses from injecting).

In this assessment, drug use refers to illicit substances covered by the Misuse of Drugs Act 1971 and the Psychoactive Substances Act 2016; substance use includes both illicit drugs and alcohol[16]. Dependency is distinct from harmful use and describes a regulatory disorder characterised by a strong internal drive to use substances, impaired control, cravings and prioritisation of substance use despite harm.

Understanding need is complex. Using Bradshaw's framework[17], this assessment focuses on *normative need* (individuals with problematic use not in treatment) and *comparative need* (differences in access between groups, such as by gender or substance type). These may not align with an individual's perceived or "felt" need (Figure 1).

Quantifying unmet need is challenging due to the absence of a comprehensive registry of people using substances. Primary data collection would be required to identify individuals not known to services, but this is limited by barriers such as stigma, fear of legal consequences, and practical resource constraints.

[14] National Institute for Health and Care Excellence (NICE). Drug misuse prevention: targeted interventions [Internet]. London: NICE; 2017. (Clinical guideline [NG64]) [cited 2026 Feb 25].

[15] World Health Organization. *Harmful pattern of use of multiple specified psychoactive substances (6C4F.1).* In: International Classification of Diseases 11th Revision (ICD-11) [Internet]. Geneva: World Health Organization; 2019 [cited 2026 Feb 24].

[16] UK Parliament. *Misuse of Drugs Act 1971* [Internet]. London: The Stationery Office; 1971 [cited 2026 Feb 24].

[17] Steinbach R., Kwiatkowska R. *Concepts of Need and Social Justice* [Internet]. London: Faculty of Public Health; 2016 [cited 2026 Feb 24].

Figure 1: Bradshaw's Framework of Need

Image source: Faculty of Public Health

Methodology

The Bexley Substance Misuse Needs Assessment used a mixed-methods approach combining epidemiological, comparative and corporate assessments, supported by a rapid review of national evidence. The methodology was designed to address the following research questions.

1. Who are the individuals using substances and not engaged with treatment services?
2. How can early identification, harm reduction and prevention be strengthened for individuals using substances?
3. How well do substance misuse services meet the needs of people who use substances?
4. How well do wider services (prison, probation, housing, employment, mental health, primary care, family services, adult social care) meet the needs of people who use substances?
5. How well do local partners in Bexley work together to support people who use substances?

Full technical details, including the search strategy and qualitative interview process, are provided in Appendix B.

Review of existing evidence (Supporting component)

A rapid review of national research, policy and clinical guidance was undertaken to provide context and identify best practice in prevention, early identification, treatment and recovery. This evidence supported the comparative assessment by offering benchmarks against national expectations.

Searches were conducted across Gov.uk, NICE, NHS England and specialist drug and alcohol organisations. Search terms covered alcohol, drugs, substance misuse, specific substances and co-occurring mental health conditions. Of 3,287 documents identified, around 1,000 were screened and 71 met inclusion criteria.

Epidemiological assessment

The epidemiological assessment examined the scale and distribution of substance-related harm in Bexley using routinely collected quantitative data. Analysis drew on ONS mortality data, hospital admissions (HES), OHID/NDTMS treatment data, alcohol and OCU prevalence modelling and demographic information. Five-year trends were explored where available, including pre- and post-COVID patterns. Data were stratified by age, sex, deprivation and substance type, and treatment coverage was assessed by comparing prevalence estimates with the treatment population.

Comparative assessment

The comparative assessment benchmarked Bexley against London, England and statistical neighbours to contextualise the local picture. Indicators such as treatment outcomes, hospital admissions and mortality were compared using national datasets (including OHID Fingertips). Where possible, comparisons were made with neighbouring Southeast London boroughs. Insights from the literature review informed interpretation by highlighting national standards and expected levels of performance.

Corporate Assessment

The corporate assessment gathered qualitative insight from stakeholders and people with lived experience to understand how substance misuse is identified, managed and experienced locally. Semi-structured interviews were conducted with 32 representatives from council services, NHS partners, police, VCS organisations, safeguarding, housing and criminal justice. Additional insight was sourced through Combating Drug Partnership subgroup meetings, group interviews with 11 service users in relapse-prevention programmes, and a survey - designed in consultation with the steering group - of 26 GPs. Data were analysed thematically to identify shared challenges, barriers to access, gaps in early identification and workforce needs.

Triangulation of findings

Evidence from all components was triangulated to strengthen reliability and ensure that conclusions reflect both quantitative data and lived experience. Quantitative patterns were cross-validated against stakeholder perspectives; issues raised consistently across multiple strands were prioritised as high-confidence findings; and emerging or hidden needs were identified where stakeholder insight highlighted issues not visible in routine data. Final recommendations draw directly on themes aligned across the three core methods.

Limitations

Epidemiological limitations

Bexley lacks direct local data on drug and alcohol use; estimates rely on national modelling and may underrepresent true prevalence. Mortality and hospital admissions may underestimate substance-related harms as they rely on coroner and medical recording practices, death records are subject to long recording delays.

Small numbers (for example among deaths and hospital admissions) limits understanding of trends and inequalities locally and incomplete data matching between services (for example probation, police and treatment services) may affect accuracy of continuity-of-care metrics.

Qualitative limitations

Interviews engaged small numbers within each service, most of whom were already engaged with the CDP, which may limit representativeness. The GP survey was limited by low engagement. A second survey was used which was limited by its design as there was no “none of the above” option for multichoice questions, potentially forcing responses. This survey was answered by 26 GPs.

Service user feedback was sought from 11 service users, who were further along in recovery limiting representativeness, and took place in front of staff, which may have biased responses.

FINDINGS

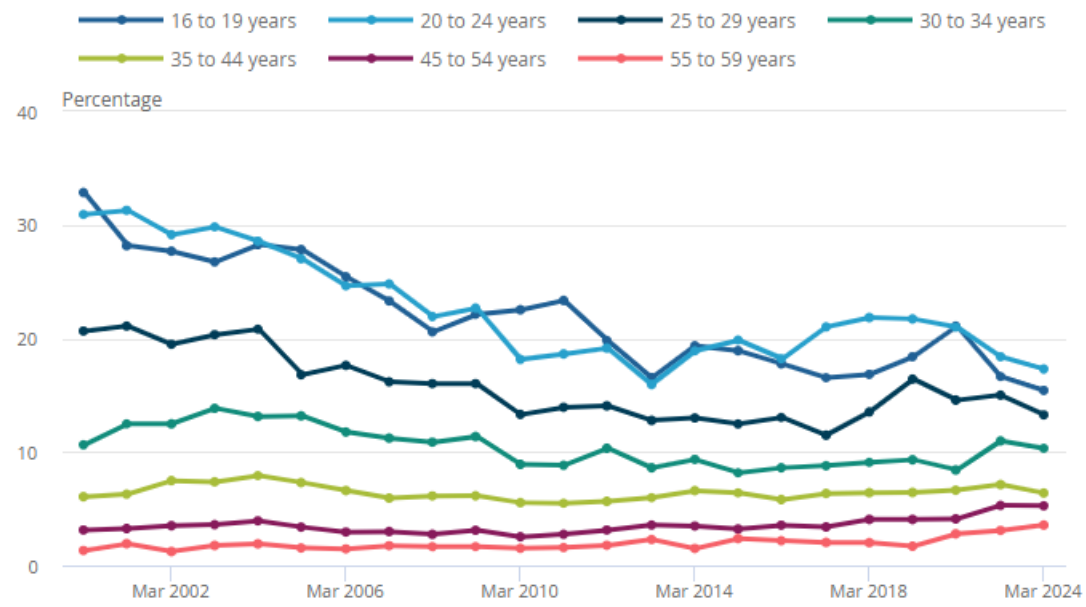
2. NATIONAL PICTURE

2.1 Patterns of drug use and harms

National data from the Crime Survey for England and Wales shows that drug use is rising following a long decline[18]. In 2023/24, 8.8% of adults aged 16-59 reported using a drug, with the highest prevalence in young adults. Use among people aged 45-59 has increased, reflecting changing patterns over time (Figure 2). Ketamine use is rising nationally, particularly among 16-24-year-olds, where past-year use has more than doubled since 2010.

Figure 2: Younger people are more likely to have taken a drug in the last year than older people

Proportion of individuals in England and Wales reporting drug use in the last year (%) by age group, year ending March 2019 to year ending March 2024



Source: *ONS. Crime in England and Wales: year ending March 2024 (2025).*

Drug-related mortality

Drug-related mortality remains one of the most severe indicators of substance-related harm and represents a major public health concern in England. There has been a steady rise in drug poisoning deaths since 2012 (Figure 3), with 5,565 registered deaths in 2024 – the highest recorded to date. Of these, 3,736 were identified as drug misuse, equating to 63.1 deaths per million people. Drug misuse deaths disproportionately affect men, who experienced more than

[18] Office for National Statistics (ONS). *Drug misuse in England and Wales: year ending March 2024* [Internet]. London: ONS; 2024 Dec 12 [cited 2026 Feb 25].

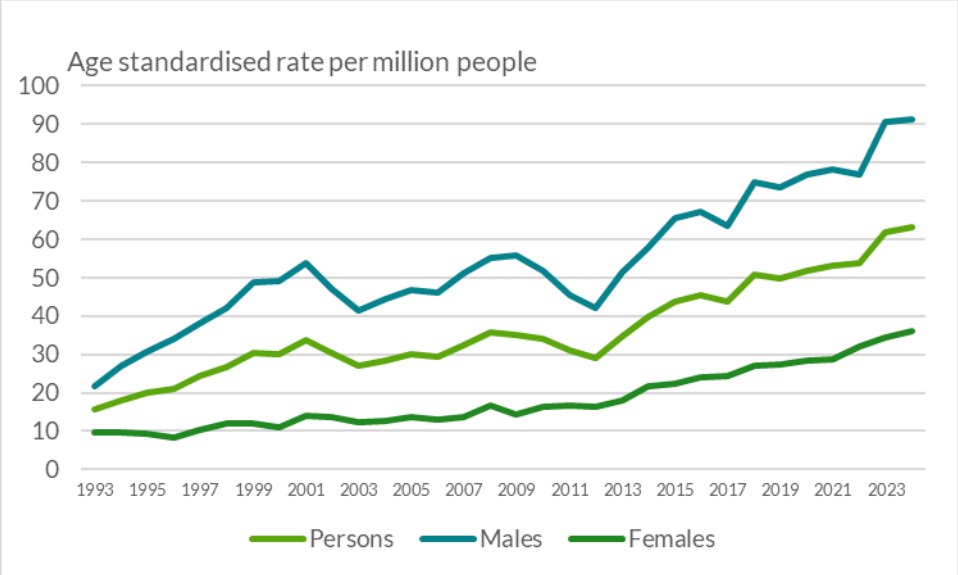
double the mortality rate of women (91.2 compared to 36.2 registered deaths per million people)[19].

Age-related patterns in drug use stand out. People aged 40-49 continue to have the highest rate of drug-misuse deaths, consistent with long-standing trends among Generation X (born between the late 1960s-1980s[20].

However, drug-related deaths extend beyond this group. In 2024, 'accidental poisoning' was the leading cause of death among adults aged 35-49, accounting for 11.9% of deaths in this age group. Among younger adults (20-34), accidental poisoning was not the leading cause of death but accounted for an even higher proportion of mortality at 14.0%[19].

Figure 3: Since 2012, the age-standardised mortality rate related to drug-misuse has increased substantially.

Age-standardised mortality rates for deaths related to drug misuse (deaths per million people) in England and Wales by sex, registered between 1993 and 2024



Source: *ONS, Deaths related to drug poisoning in England and Wales (2025)*.

Drug poisonings from selected substances

Deaths involving cocaine have risen sharply in the past 10 years

The mortality rate from cocaine has increased 10 times between 2011 and 2023 and men continue to experience a higher mortality rate than women (30.7 compared to 7.8 per million people in 2023)[19].

Opiates continue to be the most frequently recorded drug on death certificates, appearing on the death certificate of almost half of all deaths in 2024. This is a 12.8% increase from 2022, and the mortality rate has nearly doubled since 2012[19].

[19] Office for National Statistics (ONS). *Deaths related to drug poisoning in England and Wales: 2024 registrations* [Internet] London: ONS; 2025 Oct 17 [cited 2026 Feb 25].
[20] Office for National Statistics (ONS). Middle-aged generation most likely to die by suicide and drug poisoning [Internet]. London: ONS; 2019 Aug 13 [cited 2026 Feb 25].

2.2 Emerging threat: New Psychoactive Substances

New psychoactive substances are new synthetic drugs that are increasingly found in the UK drug market. They include synthetic opioids, synthetic cannabinoids and synthetic catathionones.

Potent synthetic opioids are typically much stronger than heroin. They have become a rising concern since 2023 owing to the high risk of overdose because individuals may not be aware they are ingesting them if they have unknowingly been added to opioids or other drugs (a process called adulteration).

Although it is to be interpreted cautiously, as counts of deaths are based on reports to the National Crime Agency and OHID rather than official death registries, the Drugs Early Warning System[21] has shown a significant drop in deaths due to synthetic opioids, from 308 in year ending June 2024 to 172 in year ending June 2025, possibly due to increased control in China[22].

The government guidelines on local preparedness for synthetic opioids[23] includes 12 recommendations for CDPs, OHID and the national JCDU to improve local preparedness and response. The JCDU advises that local potent synthetic opioid response plans follow the structure of Prepare, Monitor, Treat and Enforce.

To address the emerging threat of new psychoactive substances, the UK government has launched a national campaign aimed at young people aged 16-24, warning of the dangers associated with synthetic opioids (and of ketamine and THC-adulterated vapes)[24].

2.3 Alcohol consumption and harms

Findings from the Health Survey for England demonstrate that frequent drinking (five or more days per week) and consuming more than the recommended 14 units per week are more common among men and increase with age[25]. Despite older adults drinking more frequently and exceeding 14 units per week, AUDIT scores[26] decline with age, suggesting lower levels of hazardous alcohol consumption (consuming high quantities of alcohol less frequently, or binge drinking) and a higher tendency in younger adults towards binge drinking patterns of consumption[25]. Long-term trends show a decline in the proportion of adults who drank at all in the last week, drank on more than five occasions, or exceeded 14 units.

In keeping with declining reports of alcohol consumption, fell 11.8% between Q2 2021 to Q2 2025 (from £4,407 to £3,888)[27].

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[21] Department of Health and Social Care (DHSC). NDTMS Drugs Early Warning System [Internet]. London: DHSC; 2025 Dec [cited 2026 Feb 23].
[22] United Nations Office on Drugs and Crime (UNODC). *July 2025 – China: Announcement of class scheduling of 'nitazene' analogues* [Internet]. UNODC Laboratory and Scientific Service Portals; 2025 Jul [cited 2026 Feb 23]
[23] Home Office. *Local preparedness for synthetic opioids in England.* London: Home Office; 2025.
[24] Department of Health and Social Care; Dalton A. *Young people given stark warning on deadly risks of taking drugs* [press release]. 16 October 2025. London: Department of Health and Social Care; 2025 [cited 2026 Feb 25].
[25] NHS Digital. *Health Survey for England, 2022: Part 1* [Internet] London: NHS Digital; 2024 Jun 6 [cited 2026 Feb 25].
[26] Alcohol Use Disorders Identification Test (AUDIT). *Scoring the AUDIT*. [Internet] [cited 2026 Feb 25].
[27] HM Revenue & Customs (HMRC). *Alcohol Bulletin commentary (August 2025 to October 2025)* [Internet]. London: HMRC; 2026 Feb 2 [cited 2026 Feb 25].

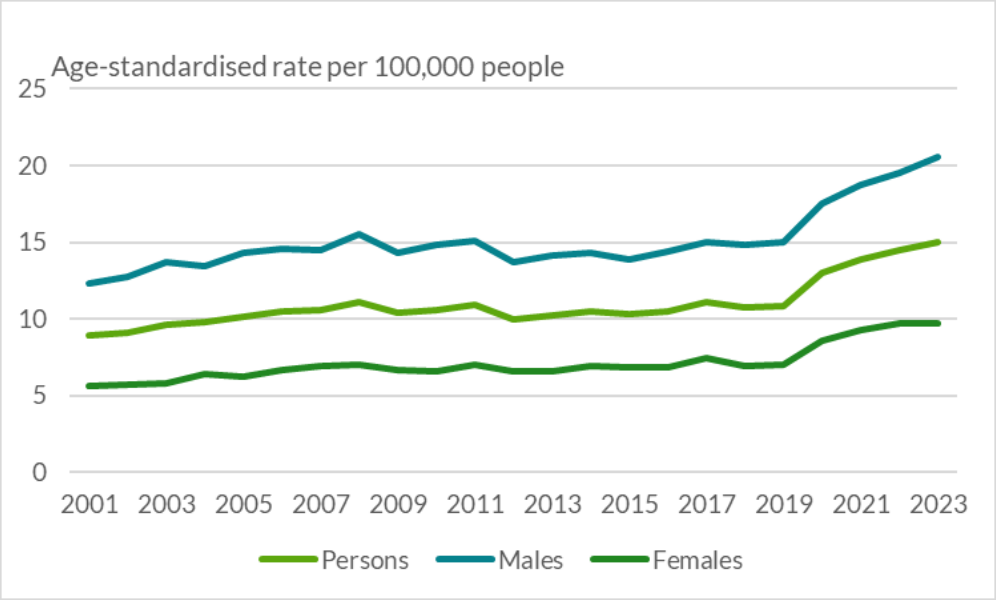
Alcohol-related mortality

Alcohol is a major contributor to mortality, playing a causal role in more than 200 diseases, injuries and other health conditions[28]. Nationally, alcohol-specific deaths are at a record high at 15 per 100,000 people in 2023 – a 31% increase over the previous five years[29] (Figure 4).

Males are disproportionately affected, experiencing a mortality rate double that of females (20.6 compared to 10.1 deaths per 100,000 people). This gender disparity is evident across measures of alcohol-related mortality.

Figure 4: since 2019, the age-standardised mortality rate from alcohol-related deaths has increased to a record high.

Age-standardised mortality rates for alcohol-specific deaths (deaths per 100,000 people) in England by sex, registered between 2001 and 2023



Source: ONS, *Alcohol-specific deaths in the UK (2025)*.

2.4 Inequalities in drug- and alcohol-related harms

Inequalities in drug-related harms

Dame Carol Black's independent review on drugs highlighted the strong social gradient in drug-related harms, with more deprived areas experiencing disproportionately high mortality rates and use of high-harm substances[1]. Compared to the 10% least deprived neighbourhoods, in 2024 the 10% most deprived experienced:

- Mortality: more than double the mortality rate due to drug misuse (8.8 compared to 3.0 deaths per 100,000)[30] (Figure 5).

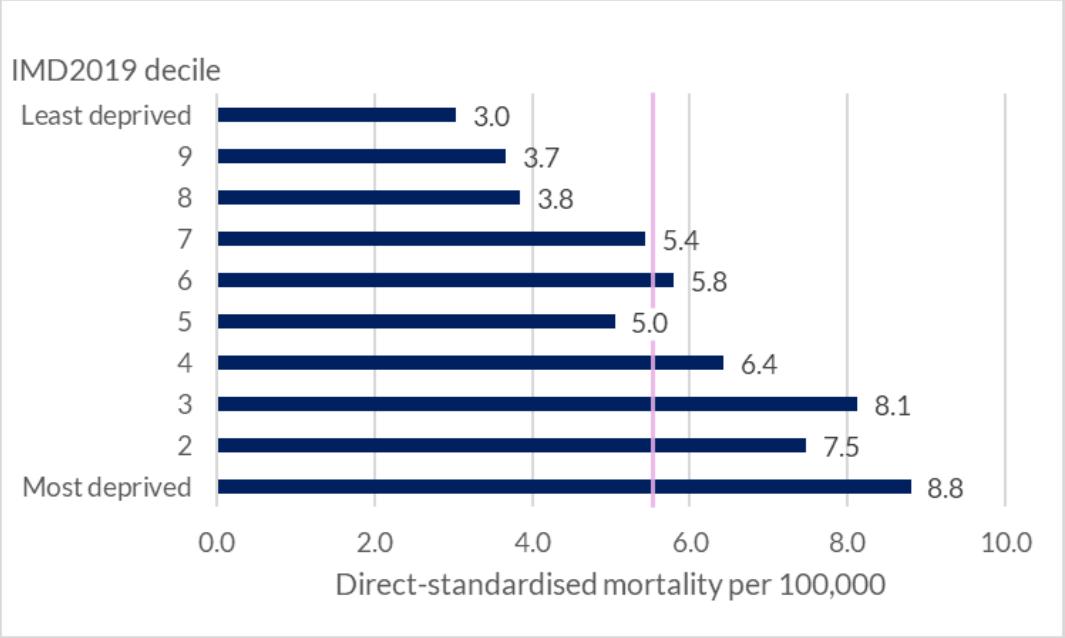
[28] World Health Organisation. *Alcohol. Key Facts* [Internet]. WHO; 2024 Jun 28 [cited 2026 Feb 23].
[29] Office for National Statistics (ONS). *Alcohol-specific deaths in the UK* [Internet]. London: ONS; 2025 Feb 5 [cited 2026 Feb 23].
[30] Office for Health Improvement and Disparities (OHID). *Fingertips: Public health profiles* [Internet]. [cited 2026 Feb 23].

- Drug-related mental health admissions: almost 60% higher rates of hospital admissions where drug-related mental and behavioural disorders are a factor (265.7 per 100,000 compared to 110.4 per 100,000)[30].
- Drug misuse admissions: almost twice the rate of hospital admissions attributable to drug misuse (22.5 per 100,000 compared to 11.8 per 100,000)[30].

Data comparing social gradients using IMD deciles do not capture the disproportionately high harm among people facing the most severe and multiple disadvantage such as substance misuse, homelessness, imprisonment and sex work. Evidence shows extremely elevated mortality in these populations: 12 times higher than expected for women and 8 times higher for men, particularly for poisoning, injury and other external causes. Mortality rates in these populations are much higher than among the most deprived individuals (IMD 1)[31].

Figure 5: mortality from drug misuse follows a strong social gradient: the most deprived individuals experience the greatest harm

Mortality from drug misuse in England (direct-standardised rate per 100,000) by IMD decile, 2021-2023. Pink line shows the national average.



Source: OHID via fingertips. *Fingertips: Public Health Profiles (2025)*

[31] Aldridge RW, Story A, Hwang SW, Nordentoft M, Luchenski SA, Hartwell G, Tweed EJ, Lewer D, Vittal Katikireddi S, Hayward AC. Morbidity and mortality in homeless individuals, prisoners, sex workers, and individuals with substance use disorders in high-income countries: a systematic review and meta-analysis. Lancet. 2018 Jan 20;391(10117):241-250. doi: 10.1016/S0140-6736(17)31869-X.

Inequalities in alcohol-related harms

People in the most deprived areas tend to drink less frequently and lower amounts of alcohol than those in the least deprived areas[25]. However, they experience increased alcohol-related harm, reflecting a strong social gradient. In 2024, the most deprived 10% of neighbourhoods experienced around twice the rate of alcohol-specific deaths and significantly higher mortality from alcohol-related conditions. Hospital admissions followed the same pattern, with almost double the rate of admission directly attributable to alcohol and markedly higher rates where alcohol was a contributing factor[32]. This mismatch between lower consumption and higher harm - known as the alcohol harm paradox – is thought to reflect cumulative disadvantage and higher exposure to other risk factors over the life course[33].

[32] Office for Health Improvement and Disparities (OHID). *Fingertips: Alcohol profile* [Internet]. [cited 2026 Feb 23].
[33] Probst C, Kilian C, Sanchez S, Lange S, Rehm J. The role of alcohol use and drinking patterns in socioeconomic inequalities in mortality: a systematic review. Lancet Public Health. 2020 Jun;5(6):e324-e332. doi: 10.1016/S2468-2667(20)30052-9.

SECTION 2 SUMMARY

National trends in drug and alcohol use and associated harms

Drug use:

- Drug use is rising after a long-term decline, including among adults aged 45-59.
- Drug poisoning deaths reached a record high in 2024, with men experiencing more than twice the mortality of women.
- New psychoactive substances are an emerging threat due to risk of overdose, although deaths linked to synthetic opioids fell between 2024 and 2025.

Alcohol use:

- Alcohol use appears to be declining, with fewer adults report drinking frequently or above 14 units per week.
- Hazardous drinking patterns are more common in younger adults, while older adults drink higher volumes.
- Alcohol-related mortality is at a record high following a five-year increase.

Deprivation:

- People living in the most deprived areas experience around double the mortality and hospital admissions from drug misuse compared with the least deprived areas.
- Despite drinking less on average, deprived communities face twice the alcohol-specific mortality – illustrating the alcohol harm paradox.

3. LOCAL PICTURE: PREVALENCE, SERVICE USER POPULATION AND UNMET NEED

3.1 Estimated prevalence of substance misuse

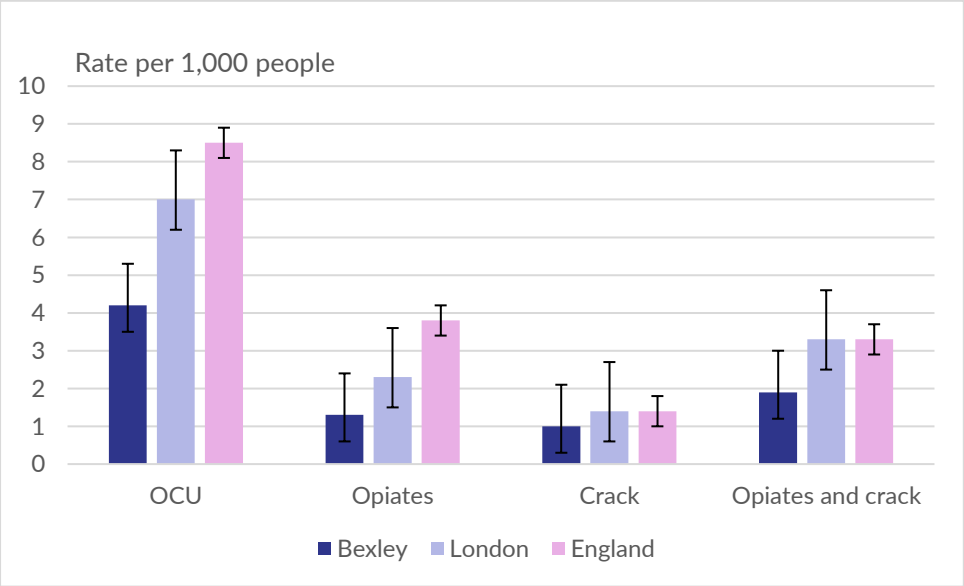
Opiate and/ or Crack users (OCU)

The estimated prevalence of OCU in Bexley in 2022/23 was 4.2 per 1,000 people, lower than both London (7.0) and England (8.5). Rates are substantially higher among men (6.9 per 1,000) than women (1.8 per 1,000) and peak among adults aged 35-44[34] (Figure 6).

Although the latest figures cannot be compared with earlier years due to a revised methodology, previous estimates showed rising OCU prevalence among adults aged 35-64, mirroring national patterns linked to older long-term opiate use.

Figure 6: The estimated rate of Opiate and/ or crack use in 2022-23 was lower in Bexley than in London and England.

Estimated prevalence of OCU, Opiate only, Crack only and Opiates and Crack use (Rate per 1,000 people) in Bexley, London and England in 2022-23.



Source: OHID via NDTMS *Treatment and Recovery Unmet Need Toolkit (2022/23)*

Alcohol dependency

Estimated alcohol dependency among adults in Bexley (11.6 per 1,000 adults) is broadly comparable to London (13.5) and England (13.8). Men are more likely to be dependent than women (18.4 compared to 5.4 per 1,000). Dependency peaks among younger adults: 17.2 per 1,000 aged 18-24, falling to 4.2 per 1,000 among those aged 55 and older[34].

[34] Office for Health Improvement and Disparities (OHID). *NDTMS Treatment and Recovery Unmet Need Toolkit* [Internet]. [cited 2026 Feb 23].

3.2 Population in treatment

All in treatment

The number of adults in treatment for substance misuse rose slightly during the COVID-19 pandemic (1,025 adults in treatment over year ending (YE) August 2021) but has since returned to pre-pandemic levels. At YE August 2025, 924 adults were in treatment in Bexley, compared to 970 and 992 in the two preceding years. This represents a 6.9% decrease since YE August 2023. Conversely, treatment numbers increased by 15.7% in London and 11.9% in England over the same period[35]. The decline in Bexley may reflect unmet need, reduced engagement locally, or a genuine fall in prevalence.

Alcohol

The decline in Bexley's treatment population is driven by falling alcohol-related presentations[35]. Between 2023 and 2025:

- Alcohol and non-opiate/alcohol clients fell 12.7% (from 519 to 453).
- Those in treatment for alcohol alone fell 17.9% (351 to 288).
- This contrasts with rising alcohol treatment numbers in London.
- Alcohol-related treatment episodes account for 49.0% of all treatment episodes.
- Alcohol remains the most commonly reported problematic substance, cited by 56.6% of all people in treatment[36].

Cannabis

Problematic cannabis use was reported by 27.2% of all in treatment over 2025[36]. It is rarely the primary reason for treatment access, typically used alongside other drugs or alcohol. This suggests a perception of low harm, and delays in help-seeking until using a substance perceived as more harmful.

Opiates and/ or crack use (OCU)

Treatment numbers for OCU remain stable (313 individuals in YE August 2025)[35]. Heroin was reported by 26.5% of clients; non-heroin opiates by 3%[36].

Cocaine

Powder cocaine use was reported by 21.5% of all in treatment in 2025, higher than London (14.8%) and England (16.5%)[36]. Numbers have remained stable in Bexley despite significant increases elsewhere. Use is more common among men, people under 30, and individuals with higher income or education[37], patterns consistent with Bexley's relatively low deprivation profile[38]. Stable local treatment numbers may indicate growing unmet need given rising national prevalence and harms[19].

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[35] Office for Health Improvement and Disparities (OHID). *NDTMS Local Outcomes Framework* [Internet]. [cited 2026 Feb 23].
[36] Office for Health Improvement and Disparities (OHID). *NDTMS New Community Adult Partnership Activity Report Beta* [Internet]. [cited 2026 Feb 23].
[37] Home Office. *Review of drugs: evidence pack*. London: Home Office; 2020.
[38] Ministry of Housing, Communities and Local Government. *English indices of deprivation 2025* [Internet]. London: HM Government; 2025 Oct 30 [cited 2026 Feb 23].

Ketamine

Ketamine treatment episodes have increased sharply following the introduction of a dedicated Ketamine treatment pathway. Between 2023 and 2025, ketamine accounted for 0.1% → 6.9% of structured treatment episodes in Bexley at PRP, far higher than London (2.2%) and England (2.5%). Most clients are aged 18–34, where ketamine accounted for 21.1% of all treatment episodes in YE 2025[36].

3.3 Service user characteristics

Age

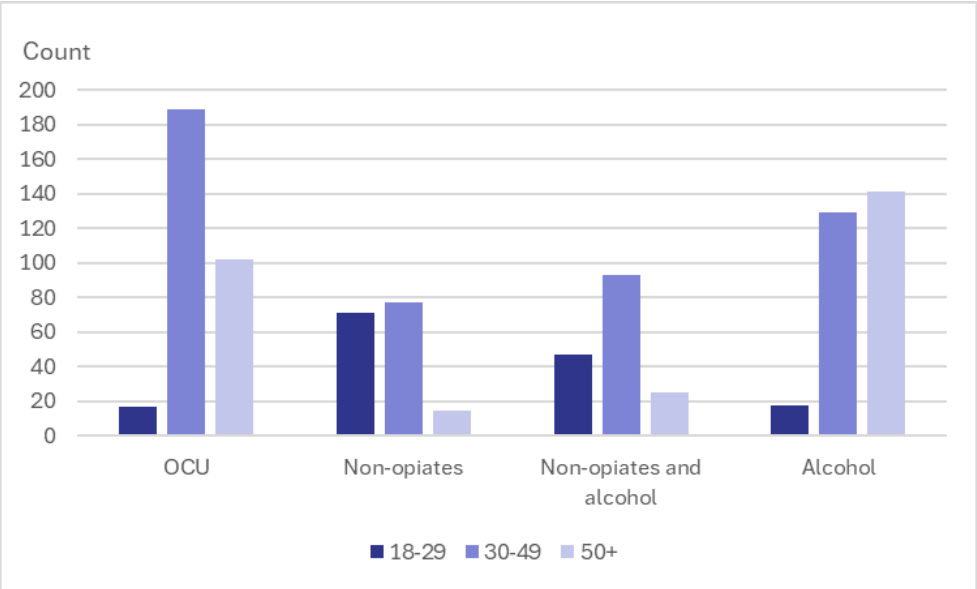
The population of adults accessing treatment for substance misuse in Bexley is ageing. Between the YE August 2019 and 2025, the number of adults aged 50+ increased by 40.3%, while the number of younger adults (18–25) fell by 30.1%. Adults aged 30–49 remain the largest cohort, but have decreased in number by almost 11%[35].

This trend is driven by an ageing population of opiate and/or crack users (OCU), which reflects national and regional patterns. The overall number of OCU in treatment has remained relatively stable but the proportion aged 50+ has risen by more than 50%, while those aged 30-49 have declined. Younger OCU (aged under 30) remain a small cohort.

A similar trend is observed among individuals accessing treatment for alcohol misuse. In the past year, for the first time, the number of adults aged 50 and over in treatment exceeded those aged 30–49 (Figure 7). Traditionally, adults aged 30–49 have represented the largest cohort in alcohol treatment services.

Figure 7: Adults aged 50+ now form a substantial cohort of individuals in treatment for OCU and alcohol.

Numbers of adults in accessing substance misuse services by substance type and age group, YE August 2025.



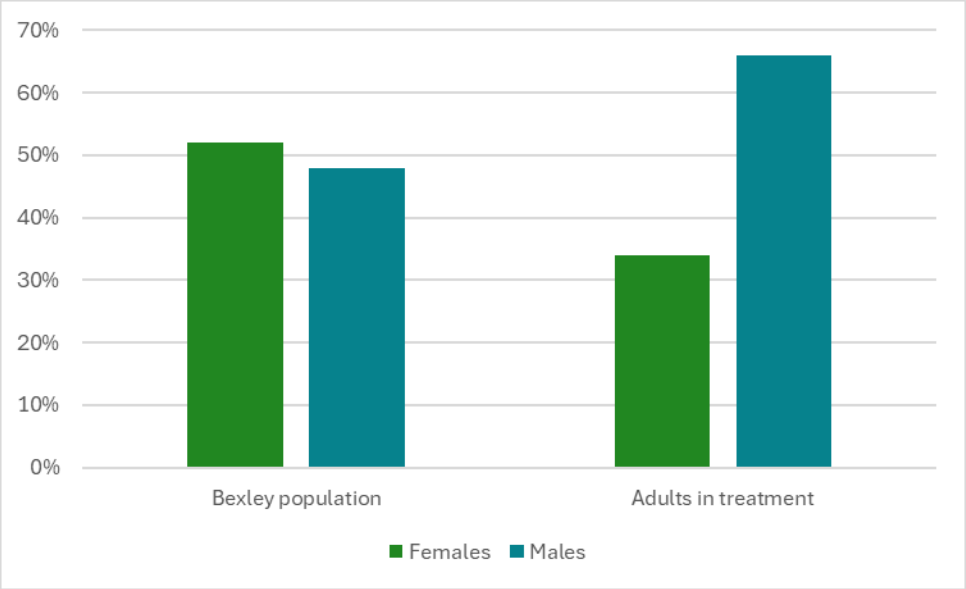
Source: OHID via NDTMS: *Local Outcomes Framework (2025)*

Sex

In Bexley, men are overrepresented in substance misuse treatment services, making up 67.4% of all in treatment (Figure 8)[35]. This pattern is also seen in London and England, and may represent a gap in need among women, where women may not access services due to barriers such as greater stigma and increased social exclusion[39, 40]. However, in Bexley there is a higher representation of women in treatment than regionally and nationally (Figure 9)[35,41]. Additionally, the overrepresentation of men in treatment mirrors gender disparities in drug- and alcohol-related harms such as hospital admissions and deaths[30,32] and data reporting prevalence of drug and alcohol use[25].

Figure 8: There is an overrepresentation of males in substance misuse treatment.

Sex distribution of Bexley population and of treatment services (%), 2025



Source: OHID via NDTMS *Local Outcomes Framework (2025)*; ONS via Bexley JSNA *Population estimates (2024)*.

[39] Simpson M, McNulty J. Different needs: women's drug use and treatment in the UK. Int J Drug Policy. 2008 Apr;19(2):169-75. doi: 10.1016/j.drugpo.2007.11.021. Epub 2007 Dec 21.
[40] Centre for Justice Innovation. Exploring women's experience of drug and alcohol treatment in the West Midlands [Internet]. 2023 [cited 2026 Feb 23].
[41] Office for National Statistics (ONS). *Estimates of the population for England and Wales. Mid-2024: 2023 local authority boundaries edition* [Internet]. London: ONS; 2025 [cited 2026 Feb 26]

Figure 9: Males are overrepresented in treatment services

Sex distribution of adults in substance misuse treatment in Bexley, London and England, 2025

	Bexley SM SU	London SM SU	England SM SU
Male (%)	67.4	69.9	68.1
Female (%)	32.6	30.1	31.9

Source: OHID via NDTMS *Local Outcomes Framework (2025)*; ONS via Bexley JSNA *Population estimates (2024)*; ONS *Estimates of the population for England and Wales. Mid-2024* (2025).

Sexual orientation

In Bexley, heterosexual individuals account for 96.1% of those in treatment compared to 90.9% of the local population (Figure 10)[35]. However, interpretation is challenging due to incomplete data: 7.0% of Bexley residents did not report their sexual orientation in the census[42]. LGBTQ+ individuals represent double the proportion in treatment compared to the general population locally, a pattern seen across London and England and consistent with evidence of increased drug use and alcohol consumption among LGBTQ+ populations[43].

Figure 10: Heterosexual individuals are overrepresented in treatment services in Bexley

Sexuality breakdown of Bexley population and Substance Misuse Service Users in Bexley, London and England (%), 2025

	Bexley		London		England	
	SM SU	Pop	SM SU	Pop	SM SU	Pop
Heterosexual	96.1	90.9	82.3	86.2	85.9	89.4
LGBTQ+	3.7	2.1	8.6	4.3	6.0	3.2
Not reported	2.1	7.0	9.1	9.5	4.1	7.4

Source: OHID via NDTMS *Local Outcomes Framework (2025)*; ONS *Census maps* (2021).
SM SU = Substance misuse service users

Ethnicity

In Bexley, individuals identifying as White British are overrepresented at PRP, accounting for 74.9% of service users compared to 65.9% of the local population (a difference of nine percentage points) (Figure 11). This pattern is also observed regionally and, to a lesser extent, nationally[35,42].

Asian ethnic groups are underrepresented in Bexley, London, and England, consistent with evidence that individuals from Asian ethnic backgrounds are less likely to report drug use Despite comparable or increased drug use and dependency among Black and mixed ethnic

[42] Office for National Statistics (ONS). *Census maps 2021* [Internet]. ONS [cited 2026 Feb 2]
[43] Pitman A, Marston L, Lewis G, Semlyen J, McManus S, King M. The mental health of lesbian, gay, and bisexual adults compared with heterosexual adults: results of two nationally representative English household probability samples. Psychol Med. 2021 Feb 17:1-10. doi: 10.1017/S0033291721000052. Epub ahead of print.

groups compared to White British, both groups are underrepresented in treatment services, particularly compared to London and England[35,42,44,45].

Figure 11: White individuals are overrepresented in substance misuse treatment services

Ethnic breakdown of adults in Bexley, London and England treatment services (%) (proportion of whole population shown in brackets) 2025

	Bexley (%)		London (%)		England (%)	
	SMSU	Pop	SMSU	Pop	SMSU	Pop
Asian, Asian British, Asian Welsh	3.9	9.9	10.0	20.7	4.0	9.3
Black, Black British, Black Asian, Caribbean, African	8.3	12.2	14.6	13.5	3.6	4.0
Mixed or Multiple ethnic groups	2.7	3.5	6.9	5.7	3.1	2.9
White British	74.9	65.9	46.0	36.8	79.3	74.4
White Other	6.6	6.0	15.9	17.0	5.92	7.3
Other	0.8	2.5	2.7	6.3	1.1	1.6
Not stated	0.8	(-)	2.2	(-)	1.6	(-)
Inconsistent/missing	0.2	(-)	1.5	(-)	1.1	(-)

Source: OHID via NDTMS *Local Outcomes Framework (2025)*; ONS *Census maps* (2021).
SMSU = Substance misuse service users; pop = whole population.

Disability

The proportion of adults newly presenting to treatment services in Bexley with a recorded disability (84.0%) is significantly higher than in London (30.9%) and England (33.2%). Over the YE September 2025, the monthly median proportion of new presentations with a recorded disability was 84.3%, compared to approximately one-third of adults in London and England[35].

This is a notable shift; 23.8% had a recorded disability in 2024/25 compared to 82.8% in 2019/20 (Figure 12). This rise is due to behavioural disabilities, accounting for 95.1% of all recorded disabilities, possibly due to higher recognition of behavioural disabilities at triage and associated recording practices. When comparing specific disability types, other notable differences emerge between Bexley, London and England:

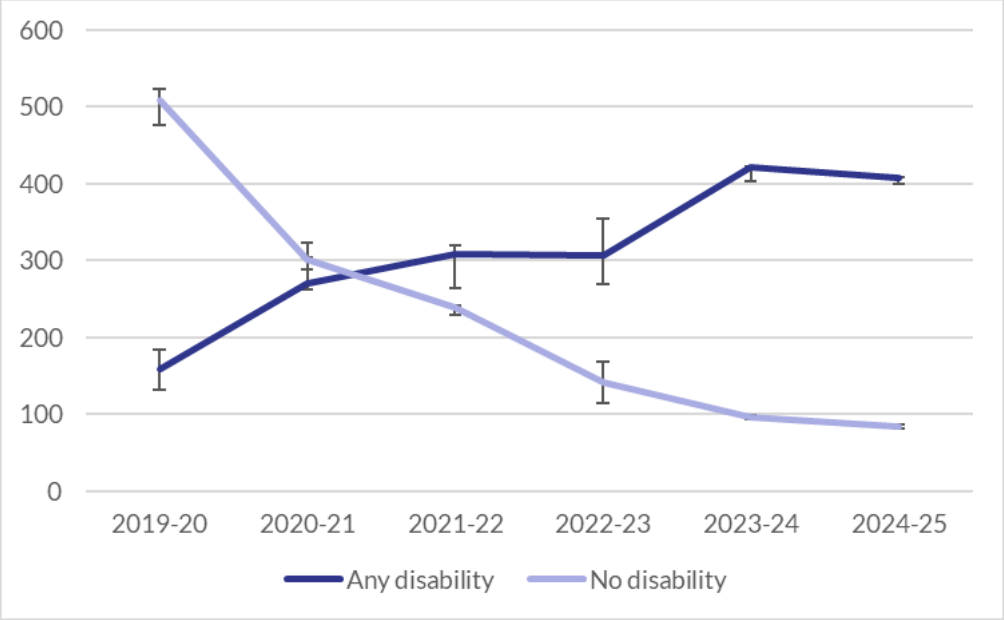
[44] Office for National Statistics (ONS). *Drug misuse in England and Wales – Appendix table. Year ending March 2025 edition*. London: ONS; 2025.
[45] NHS Digital. *Adult Psychiatric Morbidity Survey: Survey of Mental Health and Wellbeing, England, 2023/24.* 2025 Nov 27. London: NHS Digital; 2025.

- Learning disabilities: 5.9% in Bexley vs 13.8% in London and England.
- Mobility disabilities: 5.1% in Bexley vs 20% in London and England.
- Progressive disabilities: 3.4% in Bexley vs 14.2% in London and 19.1% in England.

See Appendix C for a full breakdown of recorded disabilities in treatment services.

Figure 12: The number of individuals in treatment with a recorded disability has increased over time

Median number of adults in treatment (monthly counts), by disability status (any vs no disability), 2019-20



Source: OHID via NDTMS *Local Outcomes Framework (2025)*.

3.4 Unmet Need

Understanding unmet need is essential for identifying who is not accessing treatment, where inequalities exist, and which groups may require targeted outreach or additional support. This section examines gaps in treatment engagement for opiate and crack use, alcohol dependence, co-occurring mental health needs, and wider vulnerabilities such as parental substance misuse, employment, and housing. Together, these findings highlight the populations most at risk of harm and where local systems may need to strengthen early identification, pathways, and support.

Opiate and / or crack users (OCU)

In Bexley, 306 individuals with OCU are in treatment out of an estimated 670; approximately 54.3% are not currently engaged with treatment services, similar to London and England[34]. The gender gap in treatment access is much narrower in Bexley than nationally, with 44.8% of men and 48.6% of women estimated to be in treatment locally.

Age-related inequalities are evident locally, mirroring regional and national patterns such that unmet need is estimated to be greater among younger adults. An estimated 82.4% of 15–24-year-olds with a treatment need for OCU in Bexley are not accessing treatment, compared to 36.2% of adults aged 45-64.

The estimated unmet need among individuals who use crack only is higher in Bexley and London than nationally. In Bexley, approximately 82.5% of people who use crack are not in treatment, compared to 74.1% in England.

Alcohol misuse

In Bexley, an estimated 21.5% of adults who misuse alcohol are currently accessing treatment, which is comparable to London and England. Women are more likely to be in treatment than men. Locally, approximately one third of women with an alcohol treatment need are estimated to be in treatment, compared to under a fifth of men.

There is also an age-related gradient in estimated treatment access. In Bexley, engagement in treatment increases with age, from 11.4% of young adults (18-24), to 38.8% of adults aged 55+. This pattern is consistent with London and England.

3.5 Co-occurring Mental Health, Alcohol and Drugs (COMHAD)

Unmet treatment need for people with co-occurring mental health, alcohol and drugs is rising. In Bexley, the proportion of individuals with a mental health diagnosis *not* receiving mental health treatment has increased from 13.8% to 23.3% between 2021/22 and 2024/25[35]. This rise has disproportionately affected men, whose unmet mental health need increased from 15.4% to 27.4%, compared with 11.3% to 15.9% for women (Figure 13). An increase in unmet mental health need of this scale has not been seen in London or England.

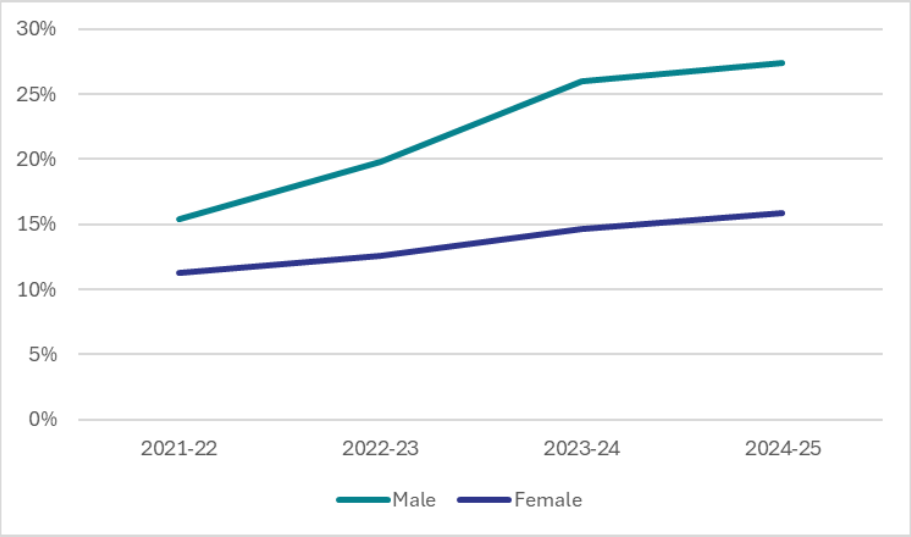
Possible explanations include:

- True increased unmet need (treatment need not being met)
- Increased recording of diagnosis
- Completion of short-term mental health interventions via the mental health hub

Local policy requires Oxleas Mental Health Services to assess all service users regardless of substance use and provide appropriate signposting or treatment 'irrespective of any opinion about cause and effect of their substance use on their mental health'[46]. This is in line national guidance promoting a 'no wrong door' approach, ensuring individuals with COMHAD can access support in both Mental Health and substance misuse settings[47].

Figure 13: there has been a disproportionate increase in the proportion of men in substance misuse treatment not in accessing care for their mental health, compared to women.

Proportion of men and women in substance misuse treatment with a mental health diagnosis who are not accessing treatment for their mental health.



Source: OHID via NDTMS *Local Outcomes Framework (2025)*.

3.6 Parental substance misuse

The Bexley parental substance misuse protocol aims to strengthen early identification and support for children and parents affected by parental substance misuse through a 'whole family' approach, improved communication and information sharing across agencies, and by listening to the voices of children, young people and families[48]. The protocol highlights the importance of professional curiosity – noticing and questioning signs of substance misuse – to gain a clear picture of the family to limit the harms of parental substance misuse. While many parents use substances without causing harm, risks increase when use is heavy, dependant, or impacts ability to prioritise their child. Harms can including neglect, unsafe co-sleeping, accidents due to lack of supervision, and in some cases direct exposure of the child to drugs and alcohol[49].

[46] Oxleas NHS Foundation Trust. *Care and treatment of service users with co-occurring mental health, drugs and alcohol problems (COMHAD)*. Version 2.2. London: Oxleas NHS Foundation Trust; 2019. Available from: Oxleas NHS Foundation Trust Intranet, Document and Policy Library.
[47] Public Health England (PHE). *Better care for people with co-occurring mental health and alcohol/ drug use conditions. A guide for commissioners and service providers.* London: PHE; 2017.
[48] London Borough of Bexley Public Health. *Bexley Multi-Agency Parental Substance Misuse Protocol.* Bexley S.H.I.E.L.D; 2025.
[49] NSPCC. *Parents with substance use problems: learning from case reviews.* London: NSPCC; 2023 Dec.

Substance misuse often co-exists with other vulnerabilities such as domestic abuse, mental health, unstable housing, social isolation.

The proportion of parents in treatment receiving parental support has increased year-on-year, now surpassing the national and regional average (Figure 14)[35]. It is notable that due to changes in recording practices, the number of parents in treatment has more than halved between 2022 and 2025. Previously, individuals were being identified as parents where they were no longer living with/ caring for their children.

The proportion of mothers receiving parental support increased from 10.6% (27) in 2021/22 to 28.7% (33) in 2024/25, while the number of mothers in treatment decreased from 256 to 115. Similarly, the proportion of fathers receiving support has increased from 15.3% (65) to 18.4% (35). This is a decrease in the absolute number of fathers receiving support, alongside a dramatic fall in the number of fathers in treatment (from 424 to 190).

Figure 14: The proportion of parents receiving support is increasing, although absolute numbers are decreasing.

Parents in Bexley in treatment receiving parental support (count and percentage of all parents in treatment) by year.

	2021-22	2022-23	2023-24	2024-25
		n (%)		
Bexley	91 (13.4)	82 (18.2)	81 (23.0)	68 (21.0)
London	1,822 (13.1)	1,827 (15.6)	1,736 (15.1)	1,670 (15.07)
England	17,242 (14.9)	16,911 (15.1)	17,022 (14.8)	16,793 (14.6)

Source: NDTMS

Source: OHID via NDTMS *Local Outcomes Framework (2025)*.
Denominator is parents in treatment.

Unmet need among parents using substances

Estimates suggest that unmet need among parents in Bexley compares well to national and regional levels. Using 2018/19 prevalence estimates and 2020 treatment data it was estimated that 32% of alcohol dependant adults with children in Bexley were not accessing treatment, considerably lower than national (79%) and regional (77%) levels[50].

For opiate-dependent parents, earlier estimates indicated full treatment coverage in Bexley, as the number recorded in treatment slightly exceeded the estimated number of parents with opiate dependence. This may reflect strong engagement or limitations in older population estimates.

In the year ending March 2020, adults living with children experienced higher rates of successful completion compared to adults who did not live with children, although completion rates among opiate users were low across groups[35].

[50] Public Health England (PHE). *Parents with problem alcohol and drug use: Data for England and Bexley, 2019 to 2020* [Internet]. PHE via NDTMS; 2020 [cited 2026 Feb 23].

3.7 Employment

Employment rates among service users

Only 28.0% of individuals accessing substance misuse treatment services were in employment, training or education (ETE) in Bexley in 2024-25. This is similar to London (27.3%) and England (26.8%), where previously Bexley performed favourably. Most of these individuals are in paid work, rather than training, education or voluntary work.

Employment rates are lowest among clients with OCU (16.0%) and higher among those in treatment for alcohol alone (32.9%). Women consistently have lower employment rates, reflecting barriers such as caring responsibilities, although the gender gap has narrowed due to declining male employment.

Previously, Greenwich and Bexley DWP had a designated substance misuse lead to support work coaches, but this role is no longer in place. Care leaver leads offer targeted support which improves employment opportunities among this population and is an example of good practice.

Individual Placement and Support

The Individual Placement and Support (IPS) has been funded to operate jointly across Bexley, Bromley and Greenwich, with Greenwich acting as the lead commissioner. This is a programme funded by DHSC offering intensive employment support interventions to help people with substance misuse to find and stay in work. It has been shown to be effective: evaluation has shown more than 50% of clients in the programme successfully obtained employment during the 18 months follow up and 80% achieving sustained employment for 13 weeks or more[51]. The service will be commissioned to start in Spring 2026 for a three-year period, with the model including a dedicated IPS worker for Bexley.

Individuals in treatment who are accessing benefit supports

Individuals who are unemployed, or underemployed, are entitled to Universal Credit, which uses a conditionality framework setting out requirements for a claimant to receive their entitlement. The requirements vary depending on personal circumstances and ability to work. If an individual does not fulfil their conditionality – for example attending training, skills development or work experience –they may receive sanctions on their Universal Credit (temporary reductions or stops in payments). When an individual discloses substance misuse, their conditionalities may be 'switched off' for a period to enable them to access treatment and recovery support. It is possible to appeal sanctions if they have been imposed in the presence of substance misuse[52].

In Bexley, 5,180 individuals aged 16 to 64 years were claiming unemployment-related benefits in the 2024/25[53]. If an individual has disclosed substance misuse to their work coach, this information is attached to their records. However, these data on the rate of substance misuse among individuals accessing employment support at the Jobcentre are not available in Bexley.

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[51] Office for Health Improvement & Disparities (OHID). *IPS for alcohol and drug dependence: data linkage outcomes 2024 report.* London: OHID; 2025 Sep 17.
[52] Department for Work and Pensions. *Drug and alcohol dependency: Guidance* (DEP2025-0769, V17). UK Parliament; 2025.
[53] Office for National Statistics (ONS). *Employment, unemployment and economic inactivity in Bexley* [Internet]. ONS; 2024 [cited 2026 Feb 26].

Nationally, substance misuse affects a significant minority of Universal Credit claimants (7%)[54]. Applying this proportion to claimants in Bexley, we could expect that 373 of 5,180 claimants were affected by substance misuse in 2024/25[53,54].

Universal Credit claimants frequently experience overlapping disadvantages (contact with the CJS, homelessness), mental and physical health conditions and limitations of activities of daily living. Nationally, among the 21% of Universal Credit claimants experiencing at least one of care experience, criminal justice contact, homelessness, substance dependency, over half (55%) felt that they could return to work with the right support, and one fifth felt ready to work right now[54]. In Bexley, this would correspond to 598 individuals who, with the right support, might be able to return to work[53].

Data on benefit sanctions are not available locally, and national sanction data are not broken down by vulnerabilities, making it impossible to show if substance misuse, homelessness or poor mental health increase risk of sanctions. Although few sanctions progress to appeal, many mandatory reconsiderations, and a higher proportion of appeals, are overturned, suggesting sanctions may be applied without a full understanding of a claimant's circumstances[55,56]. This suggests sanction application with incomplete knowledge of client circumstances, causing payment delays before appeal.

3.8 Housing

A decreasing proportion of service users in Bexley have been housed in stable accommodation over the past four years, with rates falling below both regional and national levels (Figure 15).

The 30-49 age group has persistently lower proportions of stably housed individuals: in the YE August 2025, 78.4% of service users aged 30-49 were in stable accommodation, compared to 85.1% of those aged 18-29 and 81.6% of those aged over 50. There were no notable differences in housing status between sexes. Individuals with OCU are much less likely to be housed in stable accommodation (63.9%) compared to those in treatment for alcohol (90.0%).

Figure 15: the proportion of individuals in substance misuse treatment services in Bexley housed in stable accommodation has decreased over time.

Substance misuse service users housed in stable accommodation, (proportion of all in treatment in brackets), in Bexley, London and England over time, year measured Sep-Aug.

	2021-22	2022-23	2023-24	2024-25
Bexley	795 (87.8)	825 (85.5)	746 (81.3)	729 (80.5)
London	32,322 (85.7)	32,002 (84.6)	34,283 (82.1)	36,521 (83.9)
England	237,444 (87.8)	245,264 (86.8)	262,326 (85.5)	275,570 (86.7)

Source: OHID via NDTMS *Local Outcomes Framework (2025)*.

[54] Department for Work & Pensions (DWP). *Research Summary: Survey of disadvantaged groups on Universal Credit covering: care experience, ex-offenders, homelessness and substance dependency*. DWP; 2025.
[55] Department for Work & Pensions (DWP). *Benefit Sanctions Statistics 2027* [Internet]. DWP; 2018 [cited 2026 Feb 26].
[56] Public Law Project. *Universal Credit sanctions: a system characterised by failings* [Internet]. London: Public Law Project; 2025 [cited 2026 Feb 26].

SECTION 3 SUMMARY

Substance use prevalence and treatment population

Prevalence

- Opiate and/ or crack use (OCU) prevalence is lower in Bexley (4.2 per 1,000), compared to London and England, higher among men, and peaks aged 35-44.
- Alcohol dependency prevalence (11.6 per 1,000) is comparable to London and England and is higher among men and younger adults.

Treatment profile

- Treatment numbers are falling in Bexley; regionally and nationally numbers have risen, suggesting possible unmet need or reduced engagement.
- Decline is driven by reduced alcohol treatment; alcohol remains the most common presenting substance.
- Cannabis is the most frequently reported problematic drug, followed by heroin, then powder cocaine.
- Cannabis is rarely used alone; individuals may delay accessing support until using a substance they perceive as more harmful.
- Powder cocaine presentations are proportionally higher than London/ England; treatment numbers remain static despite rising harms nationally.
- The cohort of adults in treatment for alcohol and for OCU is ageing.
- Men are overrepresented in treatment services; the gender gap in Bexley is narrower than regionally and nationally.
- LGBTQ+ individuals are overrepresented in treatment, consistent with evidence of higher substance use among these groups.
- White British individuals are overrepresented in treatment, Asian ethnic groups are proportionally underrepresented, Black and mixed ethnic groups are underrepresented, particularly compared with England and London.
- Bexley has a comparatively high proportion of individuals with a recorded disability (primarily behavioural). This may reflect recording practices.

Treatment access, unmet need and recovery outcomes

Unmet need

- Local treatment coverage for OCU and alcohol misuse is estimated to be broadly comparable to London and England.
- Considering OCU, unmet need is higher among men (although the gender gap is comparatively narrow in Bexley), younger adults, and people who use crack only.
- Considering alcohol, unmet need is higher among men and younger adults.
- The proportion substance misuse service users with a co-occurring mental health condition who are not receiving mental health care has increased, particularly among men. This may be due to barriers to care, recording practices, or shorter mental health treatment duration.
- The proportion of parents in treatment receiving parental support has increased, although the recorded number of parents in treatment has fallen, likely reflecting recording practices.

Recovery outcomes

- Adults living with children had higher rates of successful treatment completion compared to those not living with children.
- Locally, engagement with ETE has declined and is now in line with regional and national levels.
- The gender gap in employment has narrowed due to fewer men accessing ETE.
- In 2024/25, 5,180 residents in Bexley claimed unemployment-related benefits; applying national estimates suggests 373 may be affected by substance misuse. Many claimants experience overlapping disadvantages, although local d
- Housing stability among service users has declined over the past four years, falling below regional and national levels.

4. DRUG AND ALCOHOL HARMS

4.1 The cost of drug and alcohol harm in Bexley

The cost of drug harms

Borough-specific monetary estimates of drug-related harm are not currently available. National modelling provides a context for the scale of impact. The Independent Review of Drugs estimated the total annual cost of harms related to illicit drug use in England at around £19 billion, including crime, healthcare, deaths and other societal impacts[1]. While local cost modelling is not available, the national estimate demonstrates that drug harm represents a substantial societal cost and is likely to exert significant local pressure across health, criminal justice and community safety systems.

The cost of alcohol harms

Borough-level modelling is available for alcohol. The Institute for Alcohol Studies estimates that alcohol harm costs £98.8m per year in Bexley, equivalent to £401 per resident[57]. The breakdown of costs is as follows:

- Crime and disorder: £40.7 million, accounting for 11,986 estimated alcohol-related crimes
- Healthcare: £21.2 million
- Wider economic costs (absenteeism, reduced productivity, unemployment): £27.4 million
- Social services: £9.6 million

The estimated cost of alcohol harm (£98.8 million) is approximately three quarters of London Borough of Bexley's entire adult social care budget, illustrating the scale of the economic impact of the alcohol industry in Bexley. In this way, prevention and early intervention strategies have the potential to yield significant economic as well as health returns.

4.2 Healthcare utilisation

Health harms make up a substantial proportion of the overall harms associated with drug and alcohol use. These include not only the direct impact of dependency and need for drug and alcohol treatment, but also the wider health impacts of conditions caused or worsened by substance misuse. This includes acute conditions, such as overdoses, injuries, falls, and long-term conditions, including chronic infections relating to injecting drug use and liver disease resulting from prolonged alcohol consumption.

Urgent and emergency care services

Bexley has lower rates of ambulance calls due to alcohol and drugs than other SEL boroughs (Figure 16), suggesting that the impact on acute services may be lower. In Bexley, the rate of alcohol-related (as recorded by the paramedic) London Ambulance Service (LAS) calls was 4.4 per 1,000 people over 2023 and 2024. The rate of drug-related calls (recorded by the paramedic as 'overdose' or declared by the caller as 'Class A-related') was 2.0 per 1,000 people[58].

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[57] Institute for Alcohol Studies (IAS). *Cost of alcohol harm in Bexley 2021/22.* IAS; 2024.
[58] Greater London Authority (GLA). *Safestats: LAS calls 2023, 2024* [unpublished data]. London: GLA; 2025.

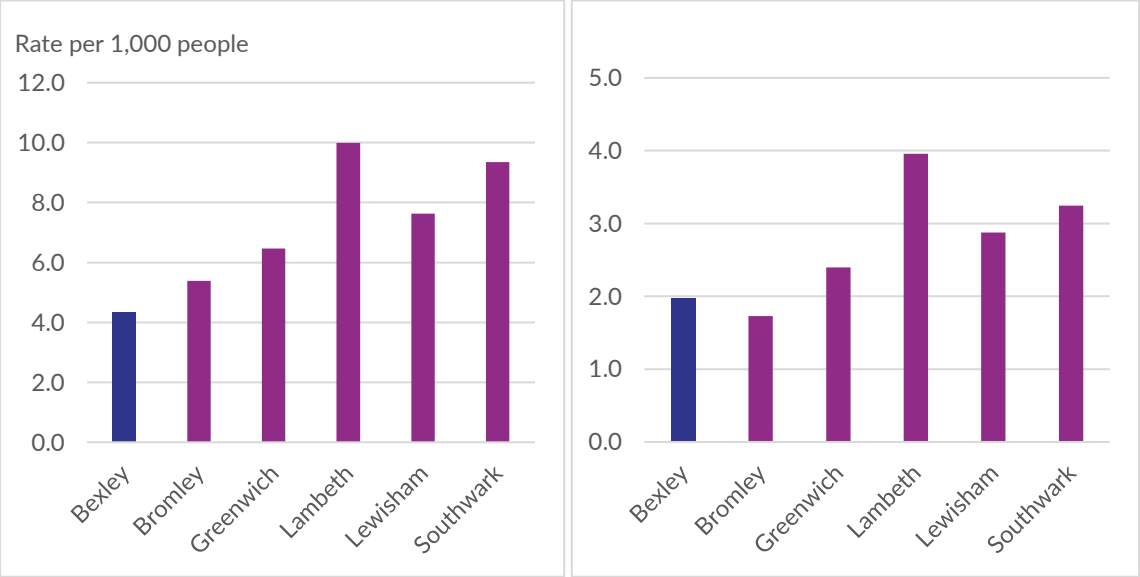
The estimated cost of an ambulance trip is £459 when it results in conveyance to the Emergency Department (ED) and £327 when it does not, therefore these trips would be estimated to cost the NHS between £5.7 and £8 million.

These data may be affected by misclassification Numbers may be overestimated if calls recorded as 'Class A drug-related' reflect misuse of prescribed controlled drugs. Conversely, they may be underestimated, as many drug-related emergencies are not due to overdoses, and alcohol involvement is often not identified or may not be documented.

Appendix D presents data on drug- and alcohol-related 111 calls, which show a similar pattern, with Bexley experiencing comparatively low rates among the SEL boroughs.

Figure 16: Rates of alcohol- and drug-related London Ambulance Service calls are comparatively low in Bexley.

Rate of alcohol- and drug-related LAS calls per 1,000 people by SEL borough, 2023 and 2024.



Source: GLA SafeStats, *LAS calls 2023 & 2024*; (2025) [Unpublished data]; ONS *Estimates of the population for England and Wales. Mid-2024* (2025).
Left: Alcohol-related (where paramedic recorded as 'Alcohol-related'); **Right**: drug-related (where caller declared 'Class A related' or paramedic recorded as 'Overdose').

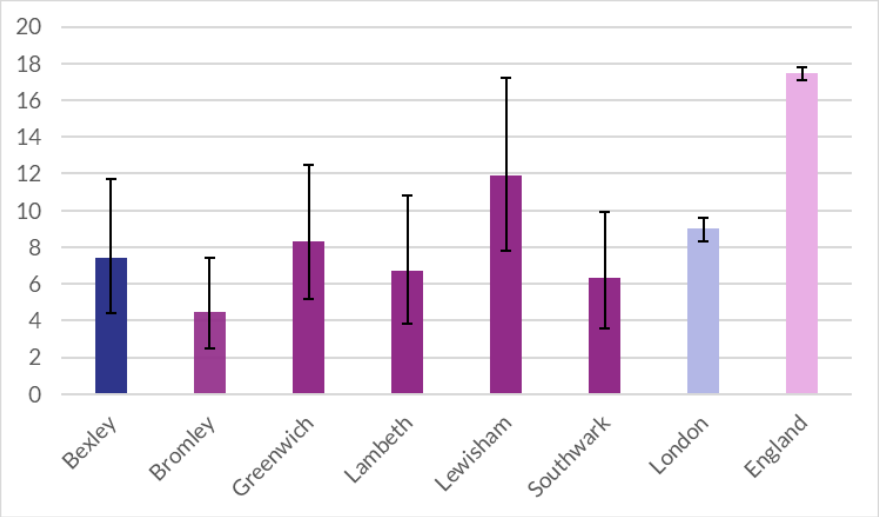
Emergency calls follow a strong age gradient; calls relating to alcohol peak aged 31-40 (2821 calls), and start to decrease among individuals over than 60. Drug-related calls are much more common among young individuals, peaking among those aged 21-40, and then declining (Appendix E).

Drug-related hospital admissions

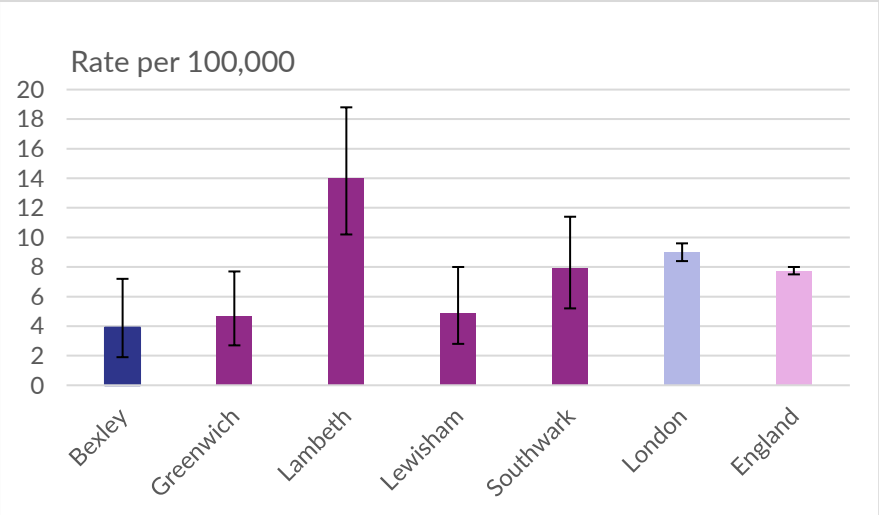
Hospital admissions linked to drug misuse provide an important indication of acute harm. In Bexley, the rate of drug-related hospital admissions in 2023/24 was 7.4 per 100,000 (poisoning by drug misuse) and 3.9 per 100,000 (drug-related mental and behavioural disorders). This is lower than or comparable with our neighbouring boroughs and with London (Figure 17)[30]. There is a pronounced gender divide in the rate of hospital admissions for drug-related mental health, with five male admissions for every two females. While nationally drug-related hospital admissions have decreased, in Bexley they have remained stable.

Figure 17: Drug-related hospital admissions are comparable with, or lower than our neighbouring boroughs

a) Hospital admissions for poisoning by drug misuse (rate per 100,000 people), in Bexley, nearest neighbours, London, England (2023/24).



b) Hospital admissions for drug-related mental and behavioural disorders (rate per 1,000 people): Bexley, nearest neighbours, London, England (2023/24).



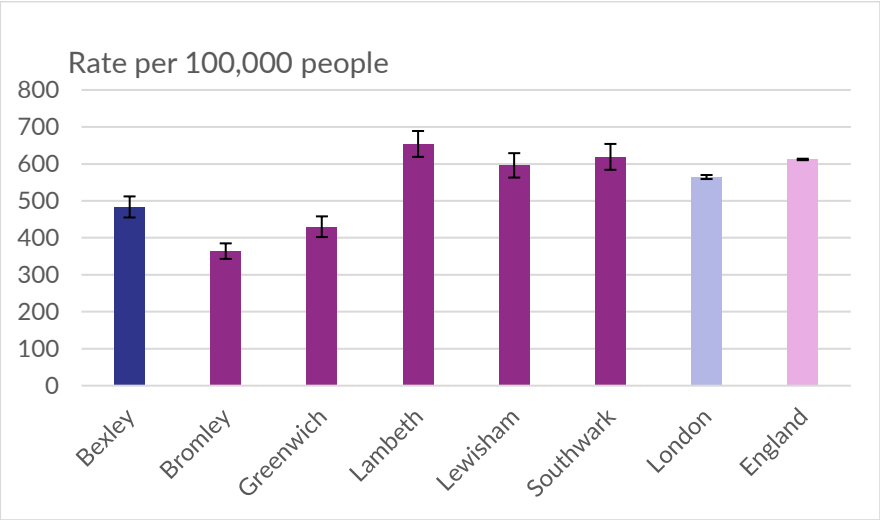
Source: OHID. *Fingertips: Public Health Profiles* (2025).

Alcohol-related hospital admissions

The rate of alcohol-related hospital admissions in Bexley was 483 per 100,000 in 2023/24. This is higher than the rate in Bromley (a statistically similar neighbour) and Greenwich but remains lower than other SEL boroughs and London (564 per 100,000) (Figure 18). Bexley has experienced an 40.4% increase in alcohol-specific hospital admissions over the preceding seven years, amid stable regional and national rates[32].

Figure 18: The rate of alcohol-attributable hospital admissions in Bexley is lower than in London and in England.

Hospital admissions for alcohol-specific conditions (rate per 100,000 people) in Bexley, nearest neighbours, London and England, 2023-24



Source: OHID. *Fingertips: Alcohol Profiles* (2025).

Inequalities in alcohol-related hospital admissions

Hospital admissions for alcohol increase sharply with age: 97.6 admissions per 100,000 among adults under 40 compared to 786.6 per 100,000 among those aged 65 and over. Men are admitted at more than twice the rate of women (2.3:1), with the gender gap widening with age, reaching 3.3 male admissions for every female over the age of 65 (3.3:1) (Appendix F).

When considering admissions where alcohol was a contributing factor (rather than the main cause), the rate in Bexley is similar to London and lower than England. In this broader measure, gender and deprivation gaps are less marked.

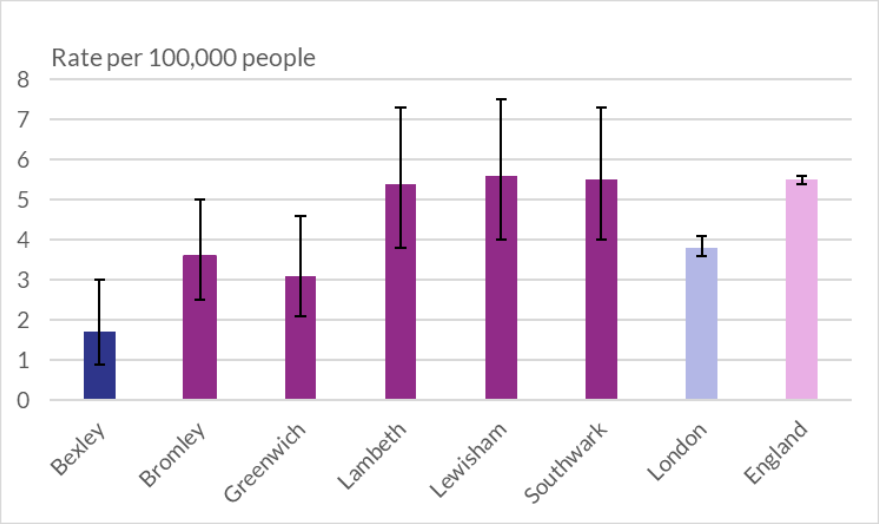
4.3 Health harms: mortality

Drug-related mortality

Deaths from drug misuse are an extreme indicator of drug-related harm. Drug-related mortality in Bexley was 1.7 per 100,000 in 2023/24, the second lowest in London (Figure 19)[30]. Deaths from drug misuse in Bexley are too few to meaningfully stratify by deprivation. However, drug-related harms are disproportionately concentrated among people experiencing disadvantage[1], underscoring the need to adopt a proportionate universalism approach to effectively reach vulnerable populations.

Figure 19: Mortality due to drug use was lower in Bexley than in London and England 2023/24

Mortality due to drug misuse in Bexley, nearest neighbours, London and England, 2023-24



Source: OHID. *Fingertips: Public Health Profiles* (2025).

Deaths due to synthetic opioids

At the time of writing, Bexley has not experienced any suspected deaths due to potent synthetic opioids. However, there have been deaths reported by OHID across London. The borough has recently updated its Potent Synthetic Opioid Response Plan in line with government recommendations[59]. One of the national recommendations is that CDPs have an effective out-of-hours resource to respond to and escalate incidents. Bexley does not currently have a Public Health out-of-hours service therefore escalation of incidents relies on existing borough emergency responses.

Deaths of individuals in treatment

The number of deaths among individuals in treatment in Bexley is very small, making it difficult to identify meaningful trends. In 2024/25, nine people in treatment died, representing just under 1% of all individuals in treatment, compared to four deaths the previous year[35].

There was a noticeable spike during the COVID-19 period (2021–23), when deaths among individuals in treatment were proportionally higher than in London and England[35]. However, the ONS measure of deaths due to drug misuse remained lower than regional and national averages during this time; many of these deaths were not directly attributable to drug misuse[30].

Alcohol-related mortality

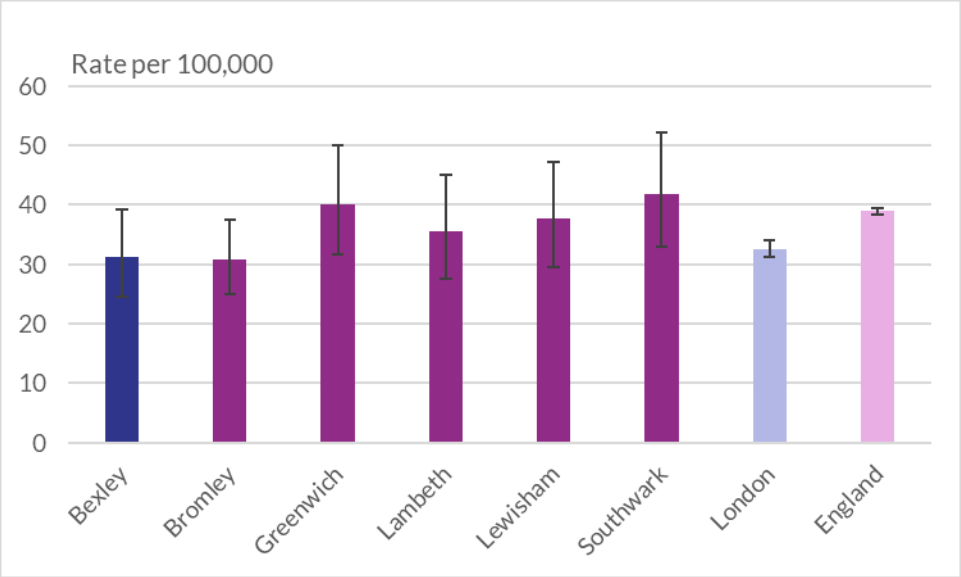
The rate of alcohol-related in Bexley was largely comparable with neighbouring boroughs and London in 2024 (Figure 20). Mortality rates due to alcohol have been stable in Bexley[32]. There is a considerable gender gap in alcohol-related mortality in Bexley. In 2024, men died from alcohol-related causes at more than three times the rate of women (50.8 deaths per 100,000 men compared to 15.3 deaths per 100,000 women). This gap is even wider locally than

[59] Bexley Combatting Drugs Partnership. *London Borough of Bexley: Potent Synthetic Opioids Response Plan*. London Borough of Bexley; 2025.

nationally, where male mortality is just under three times higher than female mortality (59.5 compared with 21.2 per 100,000)[32].

Figure 20: there was no difference in alcohol-related mortality between Bexley and London in 2024

Alcohol-related mortality in Bexley (rate per 100,000), its nearest neighbours, London and England, 2024



Source: OHID. *Fingertips: Alcohol Profiles* (2025).

Drug and alcohol related death panel

The Drug and Alcohol Related Death (DARD) panel is a multi-agency review process, typically coordinated by Public Health, responsible for conducting in-depth reviews of:

- Drug-related deaths
- Alcohol-related deaths
- Deaths occurring in substance misuse treatment
- Near-fatal overdoses

Pier Road Project (PRP) is the commissioned community drug and alcohol treatment provider in Bexley, delivering assessments, treatment, harm-reduction and recovery support on behalf of Bexley Public Health. As the primary point of contact for adults with substance misuse needs, the service plays a central role in identification, engagement and ongoing care across the local system. A more detailed overview of Pier Road Project's model, pathways and performance is provided in Section 6.2 Community drug and alcohol treatment services in Bexley: The Pier Road Project.

Pier Road Project reviews all deaths in treatment, which are primarily attributed to physical health conditions. However, reviewing drug- and alcohol-related deaths of individuals in treatment remains challenging due to delays between the occurrence of death and the inquest, which impacts timely access to case information. Currently, London boroughs do not have a data-sharing agreement to enable contemporaneous sharing of this information.

Another challenge is the reliance on accurate recognition of substance involvement in the circumstances of death. For example, if an individual dies due to an accident while intoxicated, acknowledgement of drugs or alcohol as a contributing factor depends on the availability of a collateral history to report this information for inclusion on the death certificate.

4.4 Social harms: drug-related crime

Breaking drug supply chains is a key priority of the combatting drugs strategy, with an aim to simultaneously dismantle county lines, disrupt organised criminal networks and strengthen border security, while also ensuring pathways into treatment and appropriate consequences for repeat offenders.

Project ADDER

Project ADDER is a Home Office-led initiative using a whole-systems, partnership approach to combat drug misuse by tackling both supply and demand[60]. Project ADDER sits within the Metropolitan Police Service, and in Bexley operates from the Lewisham, Greenwich and Bexley Basic Command Unit (BCU). It is based on:

- Addiction: improve access to treatment and recovery services
- Diversion: divert individuals from the CJS to support services
- Disruption: target organised criminal networks (OCNs) involved in trafficking
- Enforcement: increase arrests and charges for drug-related offences
- Recovery: support long-term recovery through integrated health and social care services

Bexley residents are similarly concerned about drug-related crime: drug-related issues were voted as the second highest crime concern and drug paraphernalia was voted as the third highest Anti-Social Behaviour priority in the Community Safety Survey (2025)[61].

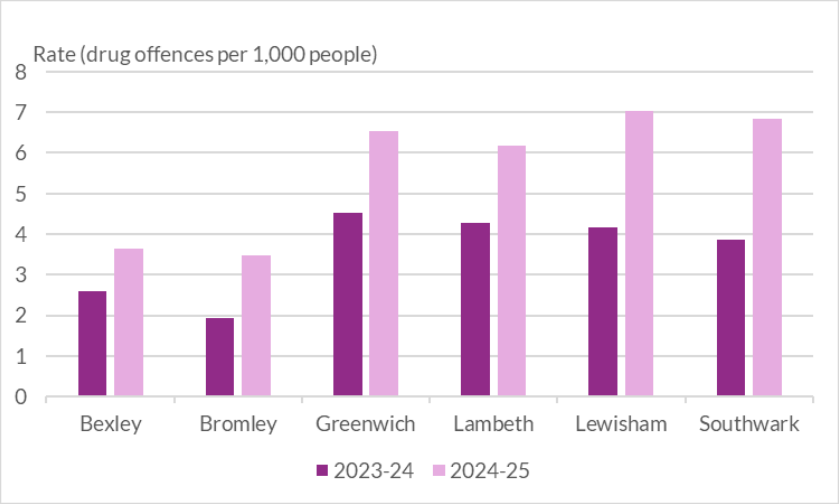
Drug offences

Across the six Southeast London (SEL) boroughs drug offences, especially trafficking, have increased (Figure 21). The increase corresponds with increased police surveillance and direction of resources due to Project ADDER. Bexley and Bromley recorded the lowest rates of drug offences in the YE August 2025 (3.64 and 3.49 per 1,000 people), while Lewisham saw the highest rate at 7.02 per 1,000 people.

[60] Department of Health and Social Care (DHSC). *About Project ADDER*. London: DHSC; 2025.
[61] Bexley Community Safety Partnership. *Joint Strategic Assessment (JSA) 2025* [Internet]. London Borough of Bexley; 2025 [cited 2026 Feb 25].

Figure 21: There has been an increase in recorded drug offences in all Southeast London boroughs

Drug trafficking and possession offences (rate of offences per 1,000 people) by Southeast London borough, YE August 2024 and YE August 2025



Source: Metropolitan Police Service. *MPS Recorded Crime: Geographic Breakdown.* London Datastore (2025). ONS *Estimates of the population for England and Wales. Mid-2024* (2025).

In Bexley, the highest rates of drug offences are seen in Bexleyheath (9.91 per 1,000 people) and the northern wards (Erith, Thamesmead East, Northumberland Health) where there are higher levels of deprivation[62] (Figure 22).

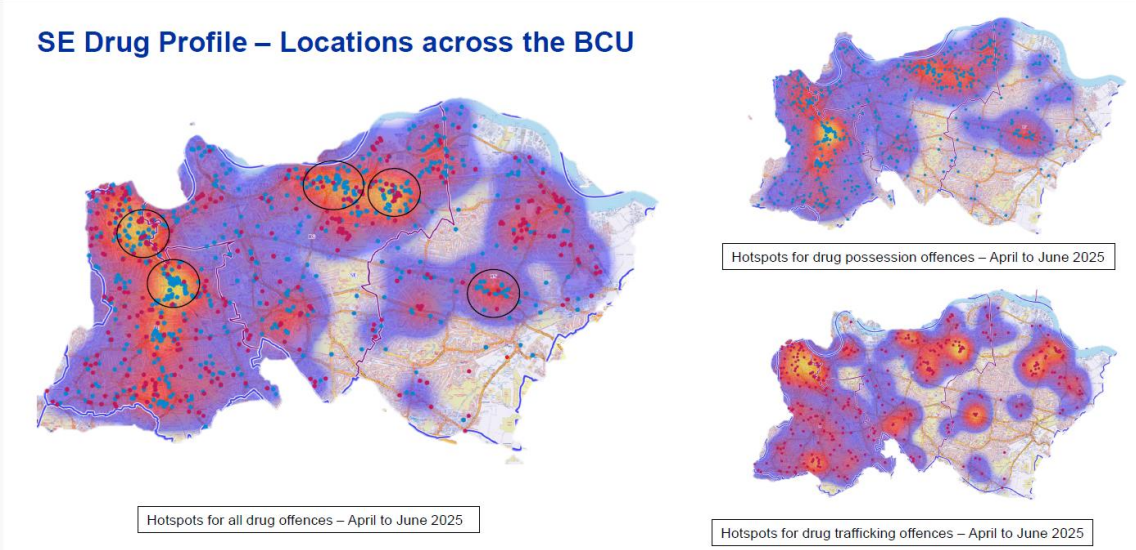
The primary determinant of detection of drug offences is police presence. The hotspot in Bexleyheath Broadway is likely due to an increased police presence linked to the nighttime economy, with offences peaking in the early-morning hours at weekends. A nearby processing unit can lead to the recording of drug offences when people are arrested for other offences and found with drugs during searches. Gaps in intelligence my limit police presence in areas where possession and trafficking do occur.

The most common drug offences in this area were possession of a controlled drug, primarily cannabis and Nitrous Oxide[63]. This pattern may reflect the high-profile nature of these substances and enforcement practices such as stop and search. It does partially align with treatment data, where cannabis is the most commonly used problematic drug[36].

[62] Metropolitan Police Service (MPS). *MPS Recorded Crime: Geographic Breakdown* [Internet]. London: London Datastore; 2025 [cited 2026 Feb 23].
[63] Metropolitan Police Service (MPS). *Project ADDER Intelligence data* [unpublished data]. London: MPS; 2025.

Figure 22: there is a hotspot for drug offences in Bexleyheath Broadway

Heat map of drug possession and trafficking offences April-June 2025 across the Lewisham, Greenwich, Bexley Basic Command Unit (BCU).



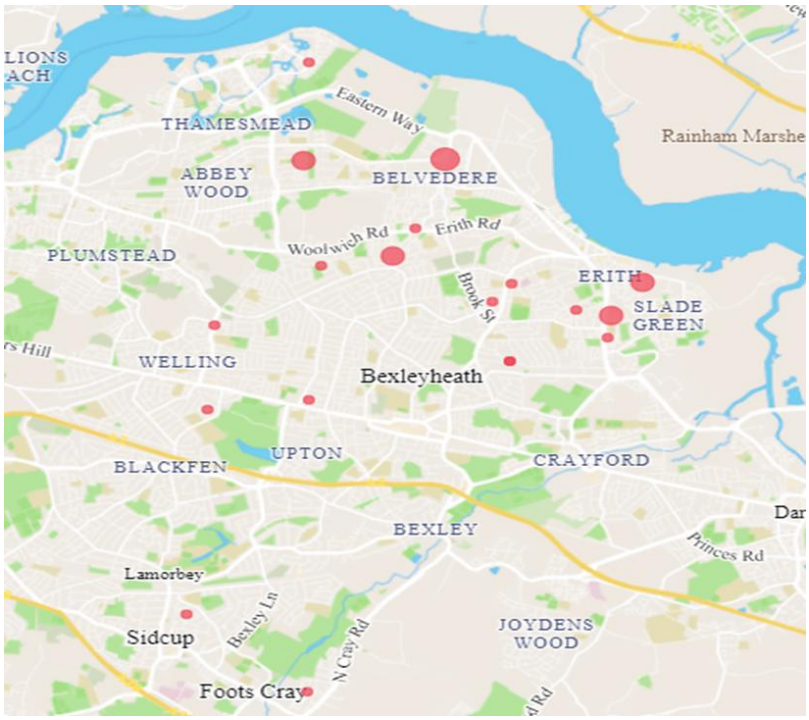
Source: Metropolitan Police Service (MPS) *Project ADDER Intelligence data* [unpublished data] (2025).

Cuckooing

Cuckooing is a process whereby criminals target vulnerable people, for example older adults, adults with cognitive impairment, learning difficulties, mental health difficulties or drug addiction, and occupy their house. The home is then used for a criminal purpose including drug cultivation and dealing. In Bexley cuckooing reports are concentrated in the North of the borough, where there is a higher level of deprivation (Figure 23).

Figure 23: Cuckooing reports were concentrated in the North of the borough, where there is a higher level of deprivation.

Map to show locations of cuckooing reports in Bexley (larger red dot = higher number of reports).



Source: Metropolitan Police Service (MPS) *Reports of cuckooing* [unpublished data] (2025).

County Lines

Bexley has excellent transport links with Kent, Sussex and into inner London, which increases the risk of county lines activity and associated harms. Local partners from the Met Police and Community Safety Team indicated that Bexley had comparatively high levels of county line disruptions in London in 2024, although formal comparative data are not published at this local level. Due to Bexley's position on key transport corridors, some county lines operating through the borough may have primary drug markets elsewhere, therefore associated harms may not be fully reflected in Bexley's local treatment or crime data[64].

[64] Coomber R, Moyle L. The changing shape of street-level heroin and crack supply in England: commuting, holidaying and cuckooing drug dealers across 'county lines'. *Br J Criminol*. 2018;58(6):1323-42. doi:10.1093/bjc/azx068.

SECTION 4 SUMMARY

Health and social harms

Cost:

- Although estimates of the cost of drug harm in Bexley are not available, alcohol harm is estimated to cost £98.8 million annually.

Healthcare utilisation:

- The rate of ambulance calls for alcohol and drugs in Bexley is lower than neighbouring boroughs.
- Drug-related hospital admissions are comparable with neighbouring boroughs.
- Alcohol-specific hospital admissions are lower than Lambeth, Lewisham and Southwark but higher than Bromley and Greenwich. The rate in Bexley has risen substantially; it is stable in London and England.
- Men are admitted at more than twice the rate of women, admissions become more common with age and the gender gap widens with age.
- Deaths from drug misuse in Bexley were the second lowest in London in 2023/24. Small numbers limit inequalities analysis.
- At the time of writing, Bexley has not experienced any deaths due to potent synthetic opioids.
- Alcohol-related mortality is lower than, or comparable with all nearest neighbours (except Southwark), with stable rates over time.
- There is a pronounced gender gap in alcohol-related mortality, more so than nationally.

Social harms – drug supply and crime:

- Bexley has one of the lowest overall drug offence rates in Southeast London.
- All Southeast London boroughs saw an increase in offences between 2024 and 2025, likely reflecting increased police activity under Project ADDER.
- Cannabis and nitrous oxide are most commonly associated with offences.
- Cuckooing is concentrated in the northern areas of the borough, aligning with known links between exploitation and deprivation.
- Good transport links in Bexley cause vulnerability to county lines.

5. THE JOURNEY INTO SUPPORT AND TREATMENT

5.1 Identifying individuals with substance misuse

Routine enquiry

Identifying individuals who use substances is a responsibility across services[10,65]. There are two routes of recognition for substance misuse:

- Individuals recognise their own drug and alcohol use as problematic and seek help;
- Service providers inquire about problematic drug and alcohol use and direct individuals towards services or deliver brief intervention themselves.

In Bexley, routine enquiry (asking all clients at first contact about substance use) is practiced by domestic abuse (Solace) and rough sleeping (Thames Reach) teams. The memory clinics screen everyone for risk of hazardous alcohol consumption. Work is ongoing at Oxleas NHS Foundation Trust (mental health services) to embed routine enquiry about alcohol, tobacco, drugs and gambling into the mental health assessment using an adapted ASSIST-Lite screening tool[66].

Other services explore substance use if risk indicators are present (inconsistent appointment attendance, signs of intoxication, or the presence of paraphernalia at home assessment). Where screening is absent, early identification relies on professional curiosity and confidence addressing substance misuse[67].

Aligning with national best practice, local workforce development reflects the principles of the 'Make Every Contact Count' (MECC) approach, which promotes early identification, brief interventions and harm reduction to prevent substance-related harms[65]. These principles underpin Bexley's Young Persons Substance Misuse Champions Network, which includes professionals who work with young people in diverse settings and meets quarterly to build awareness and confidence across sectors.

In addition, over 2025-2026 substance misuse training sessions co-ordinated by the CDP and administered by Bexley SHIELD and the Safeguarding Adults Board have included:

- Drug awareness with the Pier Road Project
- Parental Substance Misuse and Safeguarding
- Supporting Families and Carers
- Young people and substance misuse
- Talking to young people about drugs
- Cannabis and vapes

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[65] Office for Health Improvement & Disparities (OHID). *Misuse of illicit drugs and medicines: applying All Our Health*. London: OHID; 2022 Feb 23.
[66] Public Health England (PHE). *How to use the ASSIST-Lite screening tool to identify alcohol and drug use and tobacco smoking*. London: PHE; 2021 Apr 7.
[67] Bexley S.H.I.E.L.D. *Professional curiosity. What is professional curiosity?* [Internet] Bexley S.H.I.E.L.D (Safeguarding Partnership for Children and Young People) [cited 2026 Feb 26].

These training sessions have been well attended (82 of 112 spaces filled) by a diverse range of professionals from primary and secondary care, the education, voluntary and police sectors, and London Borough of Bexley council employees[68].

Specialist training is also provided by the local treatment service, Pier Road Project, for example on ketamine and naloxone administration. There is also targeted training delivered to the criminal justice workforce, for example PRP has offered training for probation workers on relapse prevention which can be delivered during their routine contacts with individuals on probation.

The importance of recognising substance misuse is underscored by the Safeguarding Adult Review (SAR) findings: of 18 SARs published in Bexley between 2021 and 2025, eight (44.4%) identified substance misuse as a contributing factor[69].

5.2 Drug Intervention Programme

The Drug Intervention Programme, part of the Diversion arm of project ADDER, identifies individuals at risk of substance misuse and supports their pathway into treatment. Police may initiate this through:

- Drug Testing on Arrest: testing individuals for 'trigger offences' such as theft, robbery or burglary.
- Inspector Authority tests: testing individuals arrested for non-trigger offences when approved by an Inspector
- Voluntary Referrals: offering a referral when someone consents, even if no charge is made.

At arrest, police test for both cocaine and opiates.

Drug testing on arrest

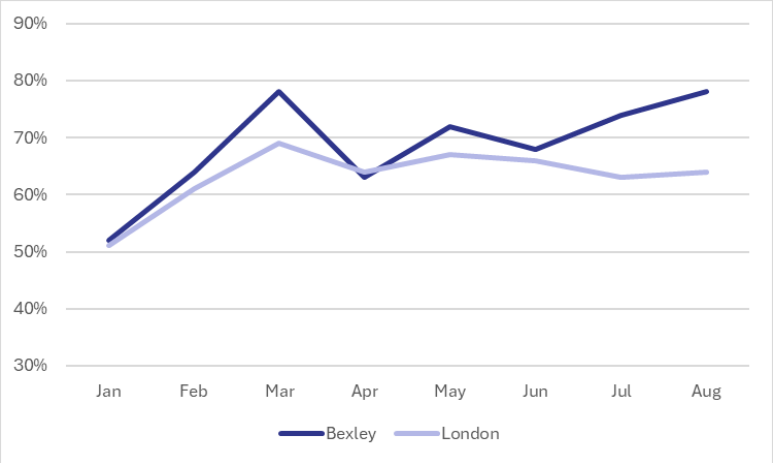
Compliance rates refer to the proportion of offences which fall into the 'trigger offence' category for which a drug test was administered. Targeted training within the BCU has contributed to improved compliance in Bexley (Figure 24).

In Bexley, 43% of tests on arrest were positive in the YE September 2025, consistent with the London average. Of these positive tests, 56% involved cocaine only, 36% both opiates and cocaine and 8% opiates only[70]. This tentatively suggests that cocaine may contribute more to crime in the borough; tests don't differentiate between powder cocaine and crack cocaine. Nationally, between March 2022 and March 2025, there has been a positive test rate of 55%, although positive tests broken down by substance are not available nationally[71].

[68] Bexley S.H.I.E.L.D. *Substance misuse training. Attendance & Feedback.* [Unpublished document] Bexley S.H.I.E.L.D; (2025).
[69] Bexley Safeguarding Adults Board (SAR). *Safeguarding Adult Reviews (SAR)* [Internet]. Bexley Safeguarding Adults Board [cited 2026 Feb 26].
[70] Metropolitan Police Service (MPS). *Drug Testing on Arrest Monthly Reports (2024/2025)* [Unpublished data]. MPS; 2025.
[71] Home Office. *Summary: Drug Testing on Arrest (DTOA) programme*. London: Home Office; 2025.

Figure 24: Compliance rates in trigger offence testing are increasing in Bexley and are consistently above the London average.

Monthly compliance with trigger offence drug testing (%) in Bexley and London, 2025



Source: Metropolitan Police Service (MPS). *Drug Testing on Arrest Monthly Reports (2024/2025)*

Drug testing on arrest is significantly more common in men, likely linked to the over-representation of men in the criminal justice system[72]. Of the 273 drug tests in Bexley, only 26 tests were completed for female residents, of which 38% tested positive. Among the 10 women who tested positive, eight completed a drug assessment in custody[73].

Inspector Authority tests allow police to test suspects of non-trigger offences on arrest. In Bexley the rate of testing is comparable to other boroughs in London. The rate of positive Inspector Authority tests is 50%, which is in line with the positive rate of 47% across London., Domestic assault was the most common associated offence (65% of tests), further discussed below[70].

Voluntary referrals, where individuals consent to referral in the absence of a charge, totalled 27 in the same period, with only 7% made for women. This was highlighted as a potential gap, as police could more often discuss voluntary referrals with victims, for example cases of Violence against Women and Girls (VAWG)[73].

Inspector Authority tests for Domestic Abuse

Domestic assault was the leading trigger for Inspector Authority tests in Bexley during YE Sept 2025, accounting for 65% of tests. Between January and September 2025, 57% of these tests were positive (34 of 60), compared to 40% in London (441 of 1,100). All of these positive tests in Bexley involved cocaine, with some also showing opiate use, suggesting that cocaine is a key driver of domestic assault locally[70].

The rate of testing for domestic assault cases remains low but is increasing. In the first six months of 2025, 6% of all domestic assault cases were subject to Inspectors Authority tests in both London and Bexley. In the same period in 2024, the rate in Bexley was 1% - the second

[72] Ministry of Justice (MoJ). *Statistics on Women and the Criminal Justice System 2023* [Internet]. MoJ; 2025.
[73] Metropolitan Police Service (MPS). Project ADDER. *Drug Testing on Arrest – SE BCU Bexley (Oct 2024 – Oct 2025)* [Unpublished data]. MPS; 2025.

largest increase in Inspectors Authority testing for domestic assault in London, where the average increase in the rate of testing was two thirds[74]. There is ongoing work among the Met Police's central VAWG team, Met Detention (who staff custody suites across London), and the Home Office to increase testing rates for domestic abuse cases across London. It is also under consideration by the home office to classify domestic abuse as a trigger offence.

Most commonly, tests are carried out due to an indicator of opiate or cocaine use from victims, perpetrators or pre-existing records. However, awareness of testing is an additional factor and has been a focus of training with a wide cohort of officers, focusing on those who investigate domestic abuse cases, along with first responders and Safer Neighbourhood Teams.

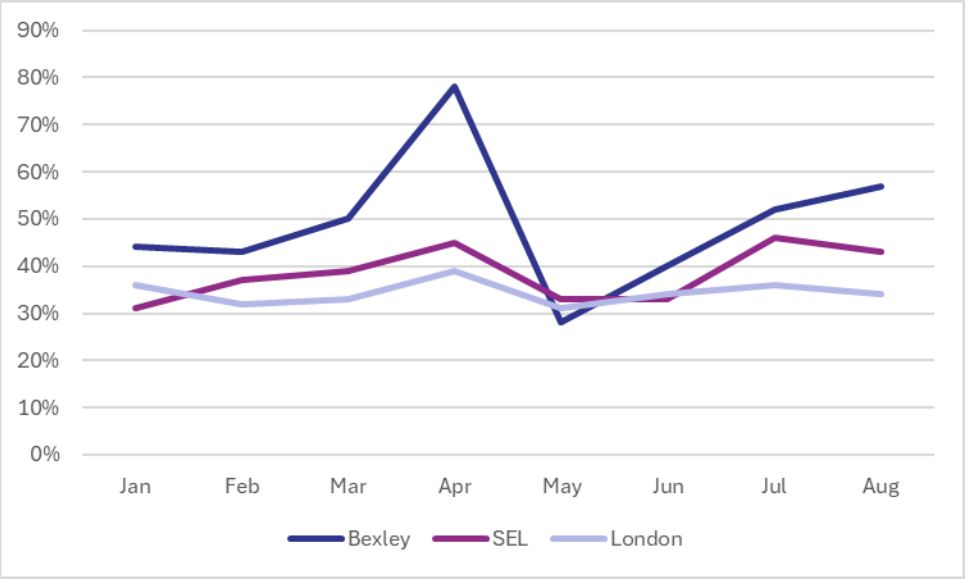
Required Assessments after positive testing on arrest

Following a positive test on arrest, individuals are referred for a Required Assessment (RA) at the PRP. Figure 25 demonstrates that, aside from a dip in May (28% of attendance compared to 33% in SEL and 31% in London), Bexley consistently achieves higher attendance rates than its nearest neighbours[70].

The Criminal Justice subgroup of the CDP attributes this in part to the success of the 'second chance' initiative, which allows individuals who miss their RA to rebook if they provide a valid reason. Over Q1 in 2025, the 'second chance rate' was 50%, meaning half of non-attenders were able to rebook and attend their RA[75].

Figure 25: Generally, a higher proportion of Required Assessments are attended in Bexley than in London and our nearest neighbours.

Required Assessments attended (percentage of appointments made) by month of 2025 in Bexley, London and nearest neighbours.



Source: Metropolitan Police Service (MPS). *Drug Testing on Arrest Monthly Reports (2024/2025).*

[74] Metropolitan Police Service (MPS). *Project ADDER Intelligence* [Unpublished data]. MPS; 2025.
[75] Bexley Combatting Drugs Partnership. *Bexley Combatting Drugs Partnership 2025/2026 Action Plan* [Unpublished data]. Bexley CDP; 2025.

5.3 Accessing support for drugs and alcohol

After an individual has disclosed drug or alcohol use, service providers can provide support directly or signpost to further support services. Appropriate support depends on the severity of substance misuse and personal preference. It may include:

- Delivery of harm reduction and brief advice by service providers (including healthcare professionals)
- Signposting to available information and advice such as NHS webpages and FRANK
- Self-support apps including DrinkCoach – an online coaching service to cut down alcohol consumption
- Lived Experience Recovery Organisations (LEROs) including 12-step programmes (AA)
- Referral into the local structured treatment service – the Pier Road Project.

Referrals into Pier Road Project

The Pier Road Project accepts referrals for any level of severity of drug and alcohol use. Referrals can be made by telephone or email, details for which are available on the Pier Road Project website. Any service providers can refer individuals into this service.

The principal referral routes are:

- Self-referral
- Signposting by a professional to self-refer
- A supervised self-referral (supported by a professional)
- Direct referral on the individual's behalf
- Referral from the criminal justice system:
    - From prison
    - Via police (following positive drug test on arrest, inspector's authority test or voluntary referral)
    - Via probation services
    - Through a court order (drug rehabilitation or alcohol treatment requirement)

Although in some circumstances self-referrals may be appropriate, allowing clients agency and independence, there is a consensus among local stakeholders that carrying out a referral on behalf of a client, or supervising a self-referral is preferable. This ensures that the referral is made, removing an additional barrier into treatment, and provides PRP with contact details to allow follow-up if a client does not attend their assessment. This is important for engagement and retention rates.

Trends in referrals into Pier Road Project

Professional referrals into treatment increased by 23.2% January–September 2025 compared to the same period in 2024 (755 vs 613). Self-referrals did not change significantly (Figure 26). The largest increases in referrals were from the Criminal Justice System (+41.4%), Children's Social Care (+39.4%), and Mental Health Teams (+22.4%) (detailed breakdown in Appendix G)[76].

These trends coincide with strengthened partnership working and training within the CYP, Mental Health and Criminal Justice CDP subgroups; expansion of the Co-occurring Mental Health, Alcohol and Drug (COMHAD) workforce; and delivery of targeted criminal justice training via project ADDER. This suggests that collaborative efforts have improved awareness and confidence around recognising drug and alcohol misuse and referring into treatment

[76] Pier Road Project (PRP). *Referral Sources into Structured Treatment* [Unpublished data]. PRP; 2025.

services. However, caution is warranted when interpreting trends based on two years of relatively small numbers and, while positive, we can't be certain that this rise reflects better identification rather than a true increase in prevalence.

Figure 26: professional referrals into treatment are increasing

Self- and professional referrals into treatment (count) 2024 and 2025

	Jan-Sept 2024	Jan-Sept 2025	Percentage change
Self-referrals	418	411	-1.7%
Professional referrals	613	755	+23.2%
Total	1,031	1,166	+13.1%

Source: Pier Road Project (PRP). *Referral Sources into Treatment*. PRP; 2025.

Thames Reach rough sleeping service referred low numbers into treatment January-September 2024 (eight individuals) and 2025 (six individuals). This is likely because the population of individuals sleeping rough in Bexley is small, and often those with substance misuse are known to treatment services already. There is strong joint working between Thames Reach and Pier Road Project, allowing arrangements for *in situ* initial assessments for individuals who can't attend services[76].

There were low numbers of referrals from adult services including domestic abuse (Solace), ASC, employment and housing services. This is likely due to a number of factors:

- Service providers signposting individuals to self-refer, rather than referring on behalf or supervising a self-referral.
- Low workforce confidence routinely enquiring about substance misuse.
- A gap in workforce training for the adult services workforce: there were 46 referrals from children's social services, where targeted workforce training has been delivered, compared to 7 referrals from ASC.
- Individuals may decline referral.
- Individuals may already be known to substance misuse treatment services.

Acute referrals from mental health services

Data from Bromley has demonstrated the significant impact of embedding COMHAD specialist practitioners within acute inpatient settings for continuity of care to community substance misuse services. At Green Parks House, the introduction of a Band 7 COMHAD role in December 2024 led to a marked increase in engagement and referrals. Referrals from the inpatient psychiatric unit to substance misuse services (Acute and Crisis) rose from 0 in Q1–Q3 2024/25 to 81 in Q4 and 70 in Q1 2025/26, against an annual target of 130. Additionally, the DNA (Did Not Attend) rate at the initial appointment improved substantially, from 26% in 2024/25 to 7% in Q1 2025/26[77].

Bexley does not have a designated COMHAD practitioner embedded within the Woodlands unit, the inpatient psychiatric hospital. This represents a missed opportunity to carry out substance misuse assessments and treatment during inpatient admission and facilitate continuity of care into community substance misuse treatment on discharge. Currently, Bexley residents admitted to inpatient psychiatric units in Bromley or Greenwich benefit from access to COMHAD practitioners during their admission. However, residents admitted to Bexley's

[77] Oxleas NHS Foundation Trust. *COMHAD Key performance and quality indicators 2025/26*. Oxleas NHS Foundation Trust; 2025.

inpatient unit (Woodlands) do not have the same access, as there is no designated COMHAD role within this setting, representing an opportunity to improve equity of access by replicating the successful model seen in Bromley and Greenwich.

5.3 Continuity of substance misuse care from prisons

People who come into contact with the criminal justice system are at increased risk of substance misuse and related harms, making continuity of care critical at key transition points. Release from prison provides an important opportunity to engage individuals in treatment, stabilise their recovery and prevent relapse or re-offending. Effective pathways between prisons, probation, and local treatment services help ensure people are identified early, supported promptly on release, and not lost between systems.

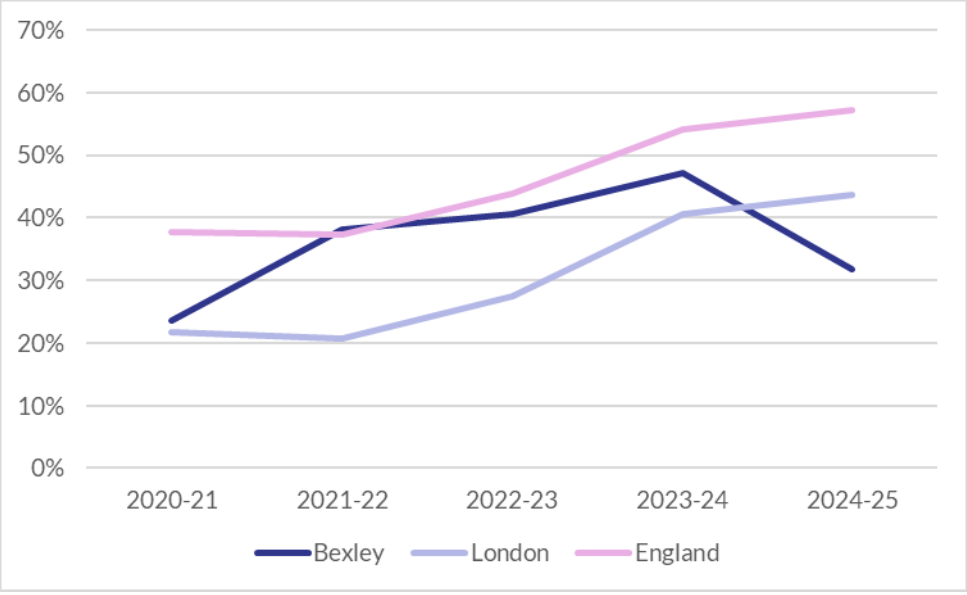
There is no local prison in the borough; residents are most frequently sent to HMP Belmarsh, followed by HMP Thameside. However, in August 2025 residents were released from 12 different prisons. Therefore, prison in-reach is challenging.

The proportion of individuals in Bexley with a substance misuse need who were seen by substance misuse services within 21 days of release from prison rose from 23.5% to 50.0% between 2020/21 and 2022/23. However, this trend was not sustained, with continuity of care declining to 31.7% across 2024/25. In contrast, over this four-year period continuity of care increased from 21.7% to 43.8% in London, and from 37.6% to 57.3% in England (Figure 27)[34].

There were discrepancies between the data from prisons and from the substance misuse service regarding continuity of care from prisons. Efforts to commence data matching between the two sources (as is the case for police referrals) is ongoing. There is a three-month data lag to account for the 21 days following release from prison.

Figure 27: The proportion of prison referrals picked up by substance misuse treatment services in Bexley has fallen below London and England

Proportion of referrals from prisons picked up within 21 days by treatment services (%) in Bexley, London and England, by year (YE May)



Source: OHID via NDTMS *Treatment and Recovery Unmet Need Toolkit (2025)*

Challenges to continuity of care from prisons

Continuity of care is particularly challenging for individuals with no fixed above (NFA), who are overrepresented in the criminal justice system[78], due to the absence of forwarding contact details from prison to treatment services and difficulty travelling to appointments. Data from Turning Point (seven boroughs) demonstrated that 44% of Bexley individuals with substance misuse imprisoned in Thameside were listed as NFA in the year ending June 2025[79].

In addition, early prison releases (at short notice) present a significant barrier to continuity of care owing to difficulties arranging timely OST prescriptions, which require an extended assessment and issuing of the script by an appropriate pharmacy. Data from Turning Point indicates that 67% of Bexley residents incarcerated at HMP Thameside with substance misuse needs were prescribed medication by substance misuse services[79]. In cases of early release, it may not be possible to dispense these scripts on time, putting individuals at risk of withdrawal and relapse.

Southeast London boroughs (and Croydon) jointly commission a prison link worker, based at HMP Thameside and managed by Turning Point, to support continuity of care on release. However, this has not translated into higher pick-up from HMP Thameside than from other prisons: in the year ending September 2025, 48.8% of Bexley residents released with a substance misuse need were seen by community treatment within 21 days (281/576), compared with 43.0% of those released from HMP Thameside (31/72)[34].

Alcohol and Drug Treatment Requirements

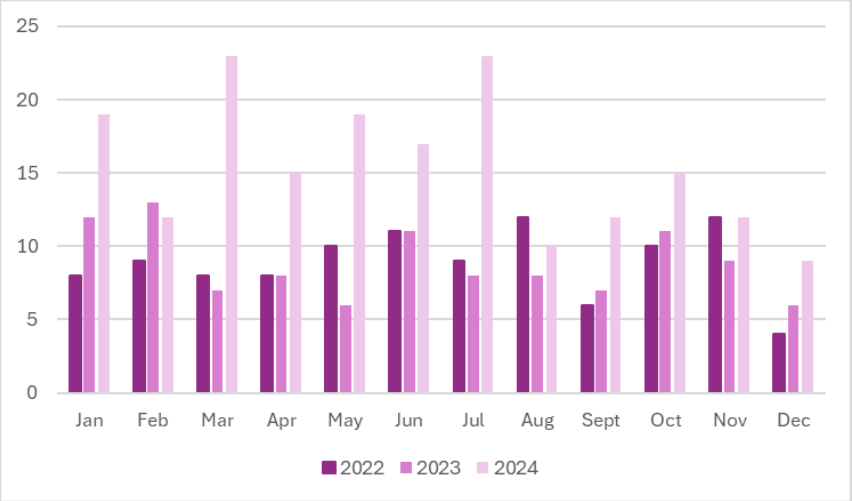
Alcohol Treatment and Drug Rehabilitation Requirements (ATRs and DRRs) are court orders which require individuals to complete a period of treatment following an offence. There is evidence that Drug Intervention Programmes reduce reoffending[80,81]. In Bexley, there are increasing numbers of individuals who are being directed into treatment with DRRs (Figure 28).

Following their initial assessment, criminal justice recovery workers recommend whether the courts should impose an Alcohol Treatment Requirement or Drug Rehabilitation Requirement. Where regular attendance would be challenging – such as in the case of no fixed abode – they do not recommend these requirements, which would increase the risk of court sanctions due to disadvantage.

[78] Ministry of Justice (MoJ). *Accommodation, homelessness and reoffending of prisoners: Results from the Surveying Prisoner Crime Reduction (SPCR) survey*. MoJ; 2012.
[79] Turning point. *Seven Borough Quarterly Report (April 2024-June 2025)* [Unpublished data]. Turning Point; 2025.
[80] UK Drug Policy Commission. *Reducing Drug Use, Reducing Reoffending*. UKDPC; 2008.
[81] Lightowlers C., *Enforced alcohol abstinence: does it reduce reoffending?* ADR UK; 2024 Sep.

Figure 28: increasing numbers are being directed into treatment using Drug Rehabilitation Requirements (DRRs)

DRR proposals across Bexley, Bromley and Woolwich courts (count), by month 2022-2024



Source: HM Prison & Probation service. *Data review for combatting drugs partnership board – Bexley.*[Unpublished data]. (2025).

5.5 Treatment progress and exits

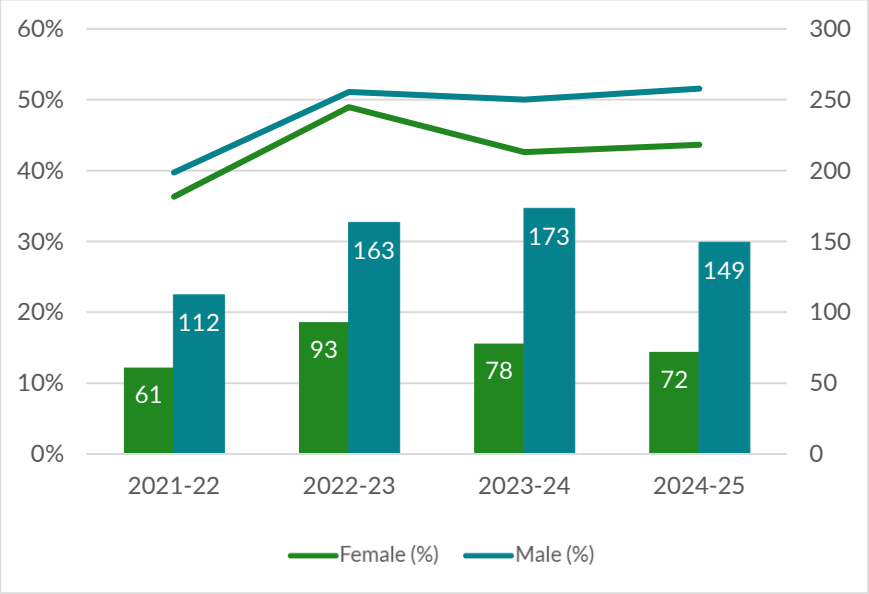
Treatment progress is defined by OHID as successfully completing treatment, being drug-free in treatment or substantially cutting down use, excluding individuals with an acute housing problem. Over the YE August 2025, 43.2% of individuals in treatment in Bexley showed substantial progress, comparable to London (44.5%) and England (46.3%). The most common reason for not showing substantial progress (59.2% of all in this category) was due to unplanned exit from treatment. Substantial progress is more common among individuals in treatment for alcohol only (49.8% of all in treatment over the last year), compared to OCU (44.9%) and non-opiates (with and without alcohol) (35.5%)[35].

Women and adults older than 50 are more likely to complete treatment, this is true for all substances. Unplanned exits among men have risen from 39.7% in 2021/22, to 51.6% in 2024/25, among women they have risen from 36.3% to 43.6% in the same period (Figure 29)[82].

[82] Office for Health Improvement and Disparities (OHID). *New Community Adult Partnership Activity Report Beta* [Internet]. London: OHID; 2025 [cited 2026 Feb 23].

Figure 29: Increasingly, men are more likely to exit treatment unplanned than women in Bexley.

Exits from treatment (count and percentage of all in treatment) over time in Bexley.



Source: OHID via NDTMS *New Community Adult Partnership Activity Report Beta.* (2025)

SECTION 5 SUMMARY

Identification of substance misuse and referral into treatment

Identifying individuals with substance misuse

- Routine enquiry is not common practice among adult services, therefore identification relies on professional curiosity and confidence.
- Workforce training can embed MECC; there may be a gap in training for adult services (outside the criminal justice system/ mental health).

Referrals into treatment

- Referrals into treatment occur via self-referral, professional referral (including supported self-referral) and criminal justice routes.
- Supervised/ direct referral is preferred to reduce barriers.
- Professional referrals into treatment are increasing, particularly from Criminal Justice, Children's Social Care and Mental Health, linked to strengthened partnership working and workforce development.
- Referrals from adult services (ASC, housing, employment, domestic abuse) are low, possibly due to workforce confidence, training gaps and signposting.
- Bexley currently doesn't have a COMHAD role in the acute psychiatric unit, in Bromley this has improved referral rates and engagement outcomes.

Diversion from the Criminal Justice System

- Continuity of care from prisons is now below regional and national levels, influenced by operational and housing-related barriers.
- Drug Testing on Arrest compliance is improving and remains above the London average.
- Cocaine is implicated in most cases – suggesting cocaine is a driver of acquisition crime and domestic abuse locally.
- Attendance at required assessment is strong, supported by 'second chances'.
- Treatment outcomes are comparable to London and England. Unplanned exits – rising among men – remain the main challenge to progress.

6. DRUG AND ALCOHOL TREATMENT SYSTEM

6.1 Funding for Substance Misuse services

The London Borough of Bexley has a statutory responsibility to commission drug and alcohol treatment and recovery services as part of their public health responsibilities. Funding for substance misuse services is from the statutory substance misuse grant within the Public Health Grant[83], supplemented by the Drug and Alcohol Treatment and Recovery Improvement Grant (DATRIG) which builds on the allocations through the public health grant in line with the recommendations from Dame Carol Black's Independent Review of Drugs[2,84]. The DATRIG combines several previous grants including the supplemental, rough sleeping, housing support and inpatient detoxification grants.

Inpatient rehabilitation is funded through the ringfenced social care budget, commissioned by the Adult Social Care complex care team.

6.2 Community drug and alcohol treatment services in Bexley: The Pier Road Project

The Pier Road Project (PRP) is the structured community drug and alcohol treatment service for adults with substance misuse in Bexley. South London and Maudsley (SLaM) NHS Foundation Trust is the provider, which subcontracts Waythrough to provide recovery-focused interventions and St Giles Trust to provide education, training and employment and wrap-around support.

PRP accepts referrals for individuals at any level of substance use and can provide brief advice, signposting and information where structured treatment is not required. They also provide family and carer support and interventions, along with wider workforce education and training.

Below is a list of treatments offered by PRP:

- Group interventions
    - Extensive group programme including (but not limited to): Introduction to treatment, Harm reduction, women's group, Motivation to change, ketamine group, relapse prevention, carer support.
- Harm reduction interventions alongside information:
    - Single-use sniff tubes for drug users who snort drugs, which reduce risk of transmission of infections such as Hep C, COVID-19 and reduce damage to the nose
    - Foil, to support a move away from injecting
    - Needle exchange
    - Supervised consumption
    - The opiate overdose reversal medication naloxone, in IM and nasal form. This is dispensed alongside overdose training and education to clients, carers and professionals.
- Advice and information

[83] Department of Health & Social Care. *Public health ring-fenced grant financial year 2025 to 2026: local authority circular*. DHSC; 2025 Jul 10.
[84] Department of Health & Social Care. *Drug and alcohol treatment and recovery funding allocations: 2025 to 2026*. DHSC; 2025 Oct 10.

- Comprehensive assessments, including physical health and Mental Health Assessments
- Clinical psychology interventions including high-intensity psychological interventions to address severe symptoms and complex needs including PTSD, anxiety, trauma. (These are time-limited in the context of treatment, offered where clients cannot access mainstream psychological services due to their substance use.)
- Keyworking
- Pharmacological interventions:
    - Substitute prescribing for opioid dependence (methadone, short- and long-acting buprenorphine)
    - Prescription of anti-craving medications (acamprosate, naltrexone)
    - Pharmacologically supported community alcohol detox pathway
    - High potency thiamine injections for prophylaxis and treatment of Wernicke's
- Substance-specific specialist treatment pathways for:
    - Ketamine (see below)
    - Alcohol
- Access to planned residential rehab
- Inpatient detox

Alongside targeted addictions treatment, PRP offers blood-borne virus testing along with facilitation of hepatitis C treatment on-site in partnership with King's college hospital. They also provide flu and COVID vaccinations and access to sexual health advice, free condoms and pregnancy tests. Smoking cessation advice is offered to all service users.

PRP includes dedicated Criminal Justice team, who carry out outreach work in prisons and are involved in working agreements with multiple areas of the CJS, including the drug intervention program, project ADDER and court orders (drug rehabilitation requirements and alcohol treatment requirements).

Ketamine treatment pathway

Bexley's is one of the few areas with a structured, evidence-informed local ketamine treatment pathway, which involves:

- Rapid access triage
- Ketamine-specific assessments
- Dedicated group programme (6-week structured intervention) focused on physical, psychological, and social harms
- Harm-reduction resources
- Specialist staff training to improve recognition and management of ketamine harms
- Pharmacological management: off-label use of naltrexone for relapse prevention(cite)
- Joint working protocols with urology services, mental health and primary care professionals

Needle Exchange

Needle exchange is a harm reduction intervention in which people who inject drugs are able to return dirty needles in exchange for clean ones. This reduces sharing of needles and paraphernalia, which decreases transmission of blood borne viruses such as hepatitis C and HIV and contributes to safer public spaces by reducing discarded injecting equipment.

Supervised Consumption

Opioid substitution therapy with methadone or buprenorphine are effective medications for opioid dependence, reducing cravings and the risk of withdrawal and minimising risks associated with injecting drugs such as blood borne viruses and bacterial infections. Supervised consumption services ensure that the patient receives the prescribed dose of OST, reduce diversion of prescribed doses, provide a regular point of contact to assess patient compliance, health and wellbeing and reduce the risk of drug related overdose and death.

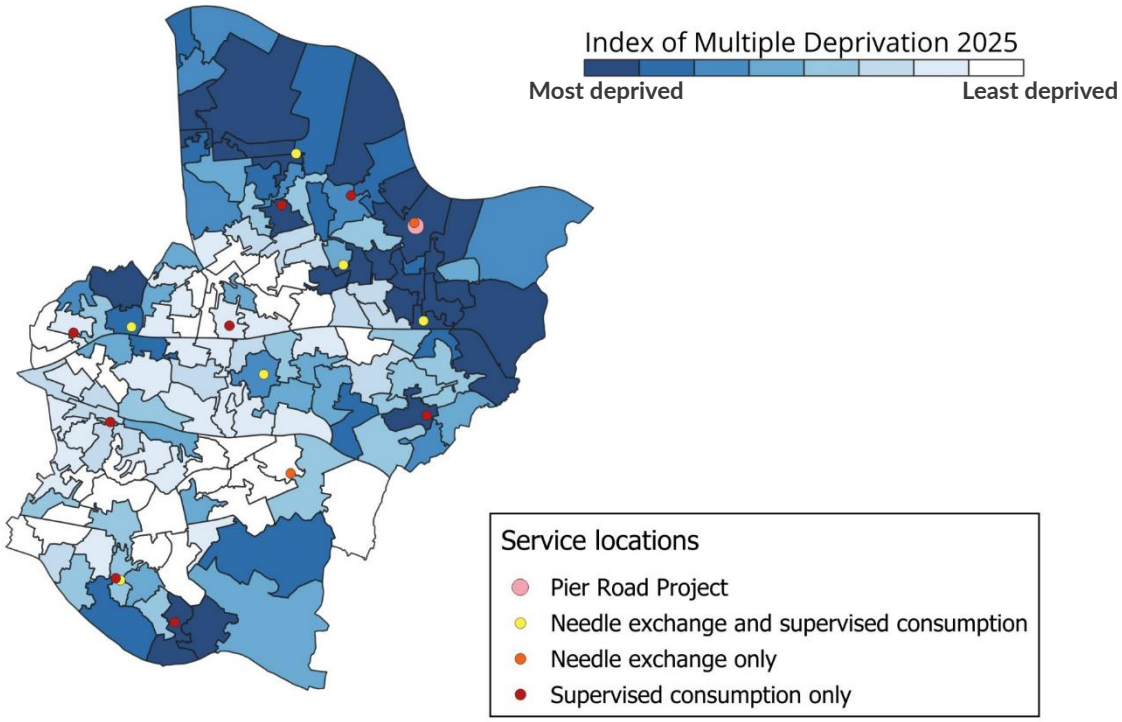
Pier road project has a formal arrangement with 16 pharmacies offering needle exchange and/or supervised consumption (Figure 30). If clients are not supervised for their OST then other pharmacies will often dispense and may supervise consumption without a formal agreement.

Service locations and equity of access

Higher levels of deprivation is associated with vulnerability to, and more harmful patterns of, drug and alcohol use[1]. Service mapping shows needle exchange and supervised consumption sites are distributed borough-wide, including in areas of higher deprivation. The Pier Road Project is also situated in an area of higher deprivation (in Erith). However, there are pockets of deprivation in the South around Sidcup. To help reduce geographical barriers to access, Pier Road Project offers teleconsultations.

Figure 30: map of service locations in Bexley by level of deprivation

Treatment services and pharmacies with formal agreement for supervised consumption and needle exchange), 2025



Source: Pier Road Project; Ministry of Housing, Communities and Local Government. *English indices of deprivation 2025*.

6.3 The workforce

Treatment Service Workforce

The PRP is staffed by a multidisciplinary workforce including:

- Medical team: consultant addiction psychiatrist, specialty doctor in addictions and resident psychiatry specialty trainee
- Nursing team: lead addictions nurse and substance use nurses (band 5 to band 7), many of whom are non-medical prescribers
- Consultant psychologist
- Needle exchange co-ordinator
- Family/ carers support worker
- Criminal justice workers
- Recovery workers
- ETE support workers
- Pharmacist and senior pharmacy technician
- Administrative team
- Smoking cessation advisor.

There are a number of volunteers and peer advisors that support the delivery of the service. PRP also supports a number of trainees across multidisciplinary professions:

- Trainee recovery workers
- Development roles for nurses
- Trainee psychologists
- Student nurses
- Medical students
- Counselling students
- Public health MSc students

Co-occurring Mental Health, Alcohol and Drugs workforce

Across Bexley, Greenwich and Bromley, the COMHAD workforce has expanded substantially over the past three years. There are now 11 COMHAD posts across the three boroughs: two in Bexley, three in Greenwich and four in Bromley, along with a clinical lead nurse working across the three boroughs. In Bexley, the COMHAD specialist practitioners are based within Oxleas. This role provides education, training and awareness, facilitates joint working between mental health and substance misuse services and manages an individual caseload.

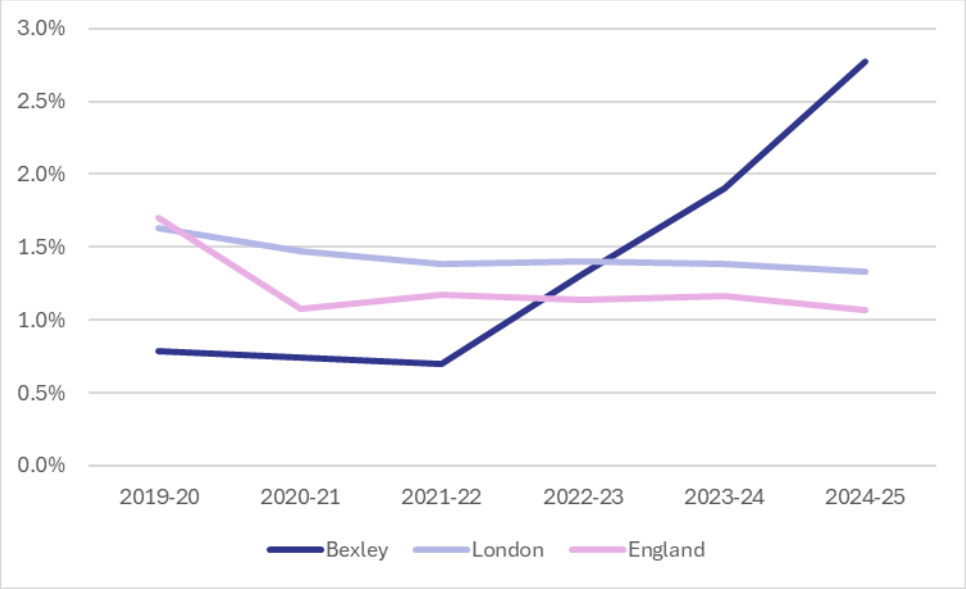
6.4 Residential rehabilitation

Residential rehabilitation is a Tier 4 treatment option for the most complex clients that enables individuals to remove themselves from environments associated with drug and alcohol use and receive intensive treatment. For this intervention to work, intensive preparation is required and clients must be carefully selected. While the NHS does not operate inpatient rehabilitation facilities, local drug and alcohol services commission placements in private residential rehab settings.

In Bexley, access to residential rehabilitation has increased (Figure 31). There were eight residential rehab encounters in 2019/20, rising to 26 encounters in 2024/25. This represents a notable increase in uptake. Residential rehabilitation now accounts for almost 3% of all individuals in treatment, which is more than double the proportion observed across London and England[35]. The target set by OHID is to offer residential rehabilitation to a minimum of 2% of individuals in treatment. Residential rehabilitation centres are based across the whole country, with very few within London. Having completed their treatment, individuals are referred back to PRP for ongoing recovery support.

Figure 31: the capacity for residential rehabilitation uptake has increased in Bexley compared to in London and England

Residential rehab uptake as a proportion of all in substance misuse treatment in Bexley (%), London and England.



Source: OHID via NDTMS *Local Outcomes Framework (2025)*.

6.5 Recovery support and lived experience

Recovery support

Recovery support services support people to sustain their recovery in the long term. They build on strengths gained in treatment, and support access to recovery communities and communities more widely[85]. They aim to:

- Increase resilience to relapse
- Optimise wellbeing
- Help grow recovery communities

The London Recovery Network was launched in 2024, aiming to bring individuals and organisations together to enable sharing of support and recovery resources[86]. Bexley is a part

[85] Office for Health Improvement & Disparities. *Part 1: introducing recovery, peer support and lived experience initiatives.* London: OHID; 2025 May 16.
[86] London Recovery Network [Internet]. 2026.

of this network and as such will be involved in emerging recovery opportunities accessible to the network across London.

Locally, St Giles Trust delivers a peer-led service to aid extended recovery for individuals facing disadvantage. It employs two case workers who provide practical support with housing, debt management and access to employment, training and education. St Giles has strong links with local partners in the statutory and voluntary sector, for example Re-Instate (employment support), Salvation Army, Foodbank, Domestic Abuse services to extend recovery opportunities. PRP also promotes self-sustaining recovery through SMART Recovery training, enabling individuals to become facilitators and support others in their recovery journey.

Despite these provisions, service users highlighted the value of ongoing recovery community support outside of treatment services – particularly for those who do not wish to access a 12-step programme. A new recovery group is currently being developed by PRP service users in partnership with PRP. This will be delivered in the community and provide ongoing, peer-led support after completion of structured or open-access treatment at PRP.

Lived experience

Work is underway to embed service user representation within the Combatting Drugs Partnership (CDP), ensuring that the voices and perspectives of people with lived experience are consistently heard and inform decision-making. This approach will also support ongoing learning from peer support and lived experience recovery organisations operating outside of PRP.

6.6 Assessment

Mapping Pier Road Project's provision against the Orange Book clinical guidelines[6] shows that the service offers a comprehensive, evidence-based model aligned with national recommendations.

Mapping of commissioning and partnership arrangements in Bexley shows that provision aligns with the commissioning quality standard[5], reflected in strong partnership working and robust service delivery across systems. It is important to note the following:

- Lived experience representation within the CDP, now established, must be embedded going forward as this has not previously been in place.
- The equality impact assessment completed as part of this needs assessment should be repeated regularly to inform ongoing planning and delivery of services and activities.
- Integrated pathways for people with co-morbid physical health needs and substance misuse are not well defined in Bexley. Physical health needs are not reflected on NDTMS and stakeholder awareness indicated this is an area that may require further exploration. Full exploration of the physical health needs of individuals with substance misuse was not possible in the scope of this needs assessment.

SECTION 6 SUMMARY

The Drug and Alcohol Treatment System

- The Pier Road Project delivers comprehensive, multidisciplinary drug and alcohol treatment across all levels of need, including harm reduction, pharmacological and psychological interventions, family support, Criminal Justice Pathways.
- Harm reduction services are well developed, with needle exchange, supervised consumption, naloxone, BBV testing and sexual health support.
- Residential rehabilitation uptake has increased and exceeds regional and national averages.
- The COMHAD workforce has expanded, which has strengthened joint working across services.
- Needle exchange and supervised consumption services are distributed across areas of higher deprivation, the Pier Road Practice is located in the North, with teleconsultation offers mitigating travel barriers. Pockets of deprivation in the south may face challenges.
- Recovery support and lived experience involvement are embedded at the Pier Road Practice and continuing to develop in the CDP and following structured treatment.
- Service provision by Pier Road Project is robust and aligns with national clinical and commissioning guidance.

7. LOCAL STAKEHOLDER VIEWS

7.1 Stakeholder insights

Qualitative insights were gathered from providers, wider partners and service users to understand identification, management and experiences of substance misuse locally.

Interviews with providers and wider partners in adult services (including council, Substance Misuse Services, NHS, criminal justice and voluntary services) took place over September – November 2025. In total 32 individuals were interviewed (full list of services included in Appendix B: Full technical methodological detail). The primary researcher also attended CDP meetings, including for the Mental Health, Criminal Justice and Children and Young People's subgroups.

Group interviews with 11 service users took place in October and November at the PRP relapse prevention group.

Questions explored access and referral, early identification and how well services meet need:

- Can you tell me about challenges that make it hard to come to treatment, from your own or seeing others' experiences?
- Can you describe times when someone could have helped you get support earlier? (like a GP, social worker or another service)
- From your experience, what is it like when professionals talk about drugs and alcohol?
- Can you tell me about anything that could have improved your treatment journey?
- Can you tell me about support you need from services to feel ready to leave treatment?

A high-level summary of the thematic analysis is provided below (full narrative summary in Appendix F).

Early identification, prevention and harm reduction

Stakeholders identified that individuals often do not view their substance use as problematic, meaning that they do not want to engage with support services. Concerns were raised by stakeholders that older people are a hidden group using substances.

Service users echoed this, describing lack of perceived risk preventing them from seeking help and that initial assessment was helpful in acknowledging potential for harm:

'Even if it wasn't a problem now, it could become a problem'.

Routine enquiry and workforce confidence addressing substance misuse and delivering brief advice is variable, with pockets of very good practice but scope for improvement. There was an appetite for workforce upskilling, but inconsistent knowledge of available training opportunities. Knowledge of the Pier Road Project exists, but there were gaps in knowledge that it accepts referrals of all severity levels and direct referral is preferrable rather than signposting. This resonated with service users, describing inconsistent awareness of PRP among professionals and confidence dealing with substance misuse:

'I say something and it doesn't go anywhere, there is no one [at the GP] for it to go to'

These highlight the need to strengthen workforce skills in brief advice and early support, rather than relying on PRP for all levels of need.

None of the service users recalled seeing the PRP advertised in GP surgeries, feeling that discrete advertising – for example used by the 12-step programme in public spaces and following late-night cash withdrawals – would discretely raise awareness for PRP.

Barriers to treatment access and recovery

Housing was repeatedly described as the biggest barrier to accessing care. Lack of forwarding detail, difficulty transitioning from rough sleeping to mainstream services, exclusion from rehabilitation when unhoused, and placement in unsuitable accommodation all contribute to reduced treatment engagement and increase risk of relapse and reoffending. One service user described remaining in an acute hospital bed for weeks due to lack of housing preventing discharge. Despite this, there were positive examples of effective advocacy, support and partnership working for people facing housing instability.

Stakeholder insights highlighted barriers to accessing care for individuals with COMHAD, primarily not being seen by mental health services due to substance misuse despite a 'no wrong door' policy. Fragmentation between mental health and substance misuse was echoed by service users: '*they were treated as separate... it took me so long to understand the link*'.

Geographical barriers to accessing treatment for individuals in the south of the borough were described, as well as barriers to access for minority ethnic groups due to fear of stigma from their own ethnic, cultural or religious communities. Service users highlighted stigma and judgement from healthcare professionals as a barrier to access, describing feeling '*seen as a junky*', and being denied help when seeking support. Others reported that they had been treated professionally and without judgement.

Substance misuse treatment services

The services offered by PRP are viewed positively, particularly the inclusivity, lack of stigma and culture of 'second chances', helping to reduce barriers to access. This was echoed by service users, who contrasted past experiences of being discharged back to the GP from NHS services for non-attendance, praising the flexibility at PRP. They described recovery workers as friendly, knowledgeable and thorough, with individualised plans and responsive care.

'*[The recovery workers] seemed very clued up*' '*It wasn't off the cuff*'

Individuals were positive about the work done by St Giles and ReInstate to support returning to work but to make their recovery journey easier, service users highlighted aftercare, describing the need for '*a community*' and '*ongoing support*'.

Service users were positive about the inpatient drug and alcohol team at Queen Elizabeth Hospital, describing them as knowledgeable and supportive in helping them enter treatment and ensuring a smooth handover to PRP

Partnership working

There is strong partnership working across the system, particularly through CDP subgroups, which have strengthened professional networks and supported workforce development. Effective collaboration was noted between substance misuse services and rough sleeping teams, as well as through MARACs for individuals with complex needs. A need for two-way communication, including timely referral updates, was highlighted. Many expressed interest in PRP-delivered outreach, which is not feasible at scale. Instead strengthening training offers, increasing awareness of availability for professional advice and building professional networks

are more sustainable ways of ensuring shared responsibility for substance misuse across systems.

Data sharing

There are inconsistencies in the recording of substance misuse across systems, particularly in general practice. Greater consistency would support a clearer understanding of individuals' needs – including those with substance misuse who are claiming employment-related benefits.

Incomplete data matching and incompatibility between systems also hinder continuity of care between services such as mental health, substance misuse and primary care – although data-sharing agreements do help this process.

7.2 Survey of General Practitioners

A survey of General Practitioners was designed in consultation with the steering group to explore confidence addressing substance misuse, knowledge of available support services, and barriers influencing patients' acceptance of support and referral pathways. The survey was circulated via the GP safeguarding network, the local care network and GP trainee network. It did not receive any responses therefore the results of a second survey, conducted February 2025 and circulated on the same platforms is included.

Key findings:

- 26 GPs responded to the survey.
- Confidence addressing drug misuse:
    - GPs reported greater confidence discussing alcohol than drugs during consultations.
    - On a scale of 1 (least confident) to 5 (most confident), average confidence was 4.2 for alcohol and 3.7 for drugs.
- Barriers to addressing substance misuse:
    - Time constraints (61.5%) and resource limitations (42%) were the most frequently cited barriers.
    - Stigma was the third most common barrier, reported by nearly a third (31%) of respondents.
- Alcohol recording in patient records:
    - Almost one quarter (23%) do not routinely record alcohol consumption
    - Over half (53%) record alcohol consumption as free text in the notes section, rather than using a coded field. This means the information cannot be easily searched or flagged in future consultations, making it harder for clinicians to see patterns or act on risks.
- Barriers to patients accepting referrals:
    - Denial of a problem was believed to be the most common reason for declining referrals (81%).
    - Fear of judgement and previous negative experience of treatments were each cited by a half of GPs.
- Facilitators to GP engagement:
    - Over three quarters of respondents (77%) would like access to local services
    - 42% requested additional training
    - 38% wanted information on patterns of drug use and symptoms to explore.
- Need for additional training:

- 42% indicated that there is a need for further education about discussing drugs/ alcohol use in their surgery, 38% indicated a possible need.
- 20% indicated that there was no need

Stakeholder insights

- Many individuals do not view their substance use as problematic. This underscores the importance of routine enquiry and early brief advice.
- Routine enquiry, brief advice and confidence addressing substance misuse are inconsistent across services, though there is an appetite for further training.
- Recording practices of substance misuse in the GP record is inconsistent.
- There is inconsistent knowledge of referrals to the PRP.
- Barriers to access include housing instability, distance for South Bexley residents, fragmentation between mental health and substance misuse services and stigma – including within minority ethnic groups.
- PRP is valued for its inclusivity, flexibility and second chances.
- There is a need for aftercare and ongoing recovery support.
- The CDP subgroups are strong partnerships, but there is scope to expand this through increased engagement from wider adult services such as employment, housing (beyond rough sleeping) and ASC.

8. WHAT DO THESE FINDINGS MEAN FOR BEXLEY?

8.1 Triangulation of findings

The findings highlight several important implications for Bexley's substance misuse system. Although national reporting has strengthened the understanding of people in treatment, gaps remain in identifying the wider population using drugs and alcohol – particularly recreational users, minority ethnic groups, younger adults with alcohol dependency and older adults with long-standing under-recognised alcohol excess. These gaps limit early intervention and suggest areas where routine enquiry, data recording and primary care engagement could be strengthened.

Alcohol misuse remains a significant concern. Despite Bexley's similar prevalence to national averages, alcohol-related deaths are highly unequal between men and women, and hospital admissions are rising locally and are highest among older adults. Combined with falling treatment numbers and stakeholder reports of normalised drinking among some older adults, this indicates potential under-identification across both age groups.

For drugs, unmet need appears to be highest among recreational users whose use escalates, cannabis users who rarely seek treatment, and individuals using powder cocaine, where local treatment trends do not reflect rising harms nationally. Cocaine has been linked to acquisition crime and domestic abuse through the Drug Intervention Programme, highlighting the broader social impact.

Inequalities in access are access are evident. People from Black and Mixed ethnic backgrounds are underrepresented in treatment despite similar prevalence of substance use, pointing to cultural and structural barriers. Geographical barriers also may be present for residents in the south of the borough, despite availability of teleconsultation.

Co-occurring mental health needs are increasing, particularly among men, shown by a growing proportion of individuals with mental health diagnoses not receiving mental health care. This may reflect barriers to access, differing clinical thresholds, or gaps in joined-up care. The absence of a dedicated COMHAD role at the local inpatient psychiatric unit creates inequity compared to neighbouring boroughs where this model has improved engagement.

There are opportunities to extend the strong CDP partnership – highlighted as a key asset - to wider adult services by strengthening ASC involvement and increasing engagement from employment and housing teams (beyond rough sleeping). Replicating the Young Persons Substance Misuse Network across adult services could support a more joined-up, multi-agency approach.

System-level challenges also shape outcomes. Workforce confidence in early identification, brief interventions and harm reduction varies across services, and stigma continues to limit disclosure. Inconsistent knowledge of referral pathways suggests opportunities to support earlier help-seeking. Housing remains a major barrier to recovery, with unstable or inappropriate accommodation increasing risks of relapse and reoffending. Employment challenges are widespread, with a low engagement from employment services and limited data on substance misuse among benefit claimants. The upcoming Individual Placement and Support programme offers a potential route to improving employment outcomes.

Continuity of care from prisons remains below regional and national levels in Bexley, impacted by early releases, inconsistent communication from prisons, limited visibility and knowledge of the link worker, and disengagement among individuals without court-ordered treatment. Finally, the local out-of-hours public health response limits preparedness for emerging risks such as synthetic opioids.

8.2 Recommendations

1: Deepen understanding of unmet need and improve access among groups at higher risk of being missed in treatment

To be led by Public Health and Pier Road Project

- Carry out targeted work to improve our understanding of need and access for among minority ethnic groups (particularly Black and mixed ethnicity), younger adults with alcohol dependency, older adults with chronic alcohol excess and residents in South Bexley.
- Carry out targeted work to understand treatment requirements and barriers to access for individuals with co-occurring mental health, alcohol and drugs.
- Further enhance visibility of self-help support and structured treatment through ongoing promotion and communication.

2: Widen early identification and supported referral by upskilling the confidence of the wider workforce in addressing substance misuse

To be led by the CDP

Expand evidence-based training approaches—currently effective in children and young people's services, criminal justice, and mental health—so they are available across wider adult services. Training should include:

- Routine enquiry
- Brief advice and harm minimisation
- The role of PRP and the treatment referral process
- Wider harms associated with cannabis use

3: Strengthen recovery outcomes for individuals in treatment

To be led by the CDP

- Embed learning from the recovery network into ongoing support for those who have completed structured treatment at the PRP
- Work jointly with housing and employment partners to remove structural barriers, specifically focusing on reducing unplanned exits among men and improving prevention and recovery outcomes

4: Consolidate multi-agency working and data sharing

To be led by the CDP

- Continue to engage with the London-wide and Southeast London systems to ensure the needs of Bexley are reflected in joint plans and projects, including preparedness for emerging synthetic opioid risks.
- Strengthen partnership working with ASC, housing and employment services to get their full participation in ongoing CDP work
- All partners to consider review of data systems to better identify individuals using drugs and/ or alcohol. Targeted work may include:
    - Improved prison-to-community information transfer on release
    - Embedding COMHAD 'no wrong door' pathways
    - Improved consistency of recording practices, including drug and alcohol use in primary care

9. KEY CONTACTS

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10. DATA SOURCES

Below is a list of data sources used for the epidemiological analysis of the needs assessment.

Data sources

National data:

- Population estimates of drug consumption: The Crime Survey for England and Wales (2024), a survey of community-dwelling individuals aged 16-59.
- Population estimates of alcohol consumption: Health Survey for England (2022), a survey of community-dwelling adults aged 16 and over delivered face-to-face.
- Drug poisonings from selective substances: ONS
- Synthetic opioid threat: DHSC via NDTMS (Drugs early warning system), uses data from the National Crime Agency and OHID to monitor the emerging threat of synthetic opioids using the number of deaths in England from potent synthetic opioids and ambulance call-outs where naloxone has been used.

Local data:

- Prevalence estimates and unmet need for opiate and/ or crack use (OCU) and alcohol: NDTMS (prevalence and unmet need toolkit).
    - OCU prevalence estimates are calculated by OHID and the UK Health Security Agency through data matching between treatment data, criminal justice records and ONS mortality data. Most recent estimates from 2022/23
    - Alcohol prevalence estimates are calculated by the University of Sheffield. Most recent estimates from 2019/20
    - Estimated prevalence provides the denominator for calculating unmet need; NDTMS treatment data provides the numerator.
- Treatment data: OHID via NDTMS (local outcomes framework) including demographics of those in treatment; education, training and employment; housing; COMHAD; continuity of care from prison; parental support; treatment retention
- Population demographics: Bexley JSNA, ONS census data (2021)
- Referrals into treatment provided by PRP
- Workforce training data provided by the CDP
- Alcohol- and drug-related hospital admissions: OHID via fingertips calculated using NHS England Hospital Episode Statistics for inpatient activity only (numerator) and ONS mid-year population estimates (denominator)
    - Drug-related hospital admissions are admissions where drug misuse was the primary reason for admission (mental and behavioural disorders or poisoning by drug misuse). It does not include hospital admissions in which drug misuse was a contributing factor, such as skin infections from injecting drugs.
    - Alcohol-related hospital admissions present alcohol-specific admissions, where alcohol was the primary reason for admission.
- Alcohol- and drug-related mortality: OHID via fingertips calculated using ONS death registrations (numerator) and mid-year population estimates (denominator)
    - Presents deaths wholly attributable to alcohol (alcohol-specific deaths), and deaths wholly attributable to drug misuse (underlying cause is drug abuse or drug dependence *and/or* any substance controlled under the Misuse of Drugs Act 1971 are involved).
- Criminal data:
    - Drug testing on arrest, inspector authority tests, voluntary referrals, cuckooing reports provided by the Met Police (project ADDER intelligence)
    - Drug offences (seizures and trafficking): met police via London Data Store
    - Alcohol and drug treatment requires: HM probation services

Population denominators:

- Mid-year population estimates 2020-2024: ONS, mid-year population estimates for England and Wales by administrative area
- English indices of deprivation 2025: Ministry of Housing, Communities and Local Government

11. APPENDICES

Appendix A: Clinical and commissioning guidelines

Below is a summary of commissioning and clinical guidelines

Commissioning Quality Standard

The Commissioning Quality Standard provides a framework to enable the provision of accessible, high quality, effective, person-centred drug and alcohol treatment and recovery systems. In doing so, it clarifies assessing local need, planning, delivering and monitoring interventions, and establishes a benchmark for local systems to measure and improve their commissioning quality over time. It is accompanied by a self-assessment tool, helping local partnerships to measure how well they meet the standards[5].

Clinical guidelines: Prevention

The Advisory Council on the Misuse of Drugs (ACMD) Drug misuse prevention review provides evidence-based guidelines on designing, delivery and evaluating prevention activities. It recommends[10]:

- Use evidence-based selective and indicated prevention following the joint United Nations Office on Drugs and Crime (UNODC) and World Health Organisation (WHO) International Standards on Drug Use Prevention[87] and National Institute for Health and Care Excellence (NICE) Drug misuse prevention guidelines[88], aligning with the European Drug Prevention Quality Standards[89]
- Avoid ineffective approaches such as fear-based or stand-alone mass media campaigns; only implement untested interventions alongside rigorous, well-resourced evaluative research.
- Address the evidence gap around effective prevention strategies for vulnerable adults through targeted research funding.
- Implement a whole-system approach and upskill the wider workforce in order to integrate universal, selective and indicated prevention across organisations.
- Avoid labelling groups as inherently vulnerable, as this contributes to stigmatisation and discrimination. Prevention should be framed around specific risk factors, contexts and behaviours that lead to vulnerability, and in doing so target the structural, environmental and social determinants of health and drug use.

Misuse of illicit drugs and medicines: applying All Our Health is an e-learning session which provides background on the harms of substance misuse and advises a 'Make Every Contact Count' (MECC) approach to prevent these harms. It advocates for early identification, brief interventions, harm reduction, safe prescribing, specialist referral and addressing underlying social determinants[65].

Clinical guidelines: Treatment

The Drug misuse and dependence UK guidelines on clinical management (known as 'The Orange Book') details the effectiveness of well-delivered, evidence-based treatment for drug misuse. It provides evidence-based standards for the assessment and clinical treatment of people who use substances. They emphasise holistic, person-centred care including comprehensive assessment, harm-reduction practices (needle and syringe provision and naloxone) and safe, effective use of opioid substitution therapy. The guidelines also advise coordinated, multi-agency working and the adoption of an approach that addresses co-existing physical, mental and social need to support recovery and reduce drug-related harm[6].

Further NICE guidelines include:

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[87] United Nations Office on Drugs and Crime (UNODC). *International Standards on Drug Use Prevention*. UNODC; 2018.
[88] National Institute for Health and Care Excellence (NICE). *Drug misuse prevention: targeted interventions* [Internet]. London: NICE; 2017. (Clinical guideline [NG64]) [cited 2026 Feb 25].
[89] European Union Drugs Agency. *European drug prevention quality standards (EDPQS)*. Lison: European Union Drugs Agency; 2011.

- NG58 – co-existing severe mental health and substance misuse: community health and social care services[7]
- CG120 - Coexisting severe mental illness (psychosis) and substance misuse: assessment and management in healthcare settings[8]
- CG51 - Drug misuse in over 16s: psychosocial interventions[9]
- CG52 - Drug misuse in over 16s: opioid detoxification[90]
- CG115 - Alcohol-use disorders: diagnosis, assessment and management of harmful drinking (high-risk drinking) and alcohol dependence[91]
- PH52 – needle and syringe programmes[92]

Public Health England (PHE) has also produced guidelines on the management of substance misuse in individuals with disabilities[93]. This highlights that people with disabilities tend to be less likely to use substances than the general population; however, this number is increasing as people with disabilities are living more independently. The guidelines details barrier to accessing care, and what we know works in the management of substance misuse among disabled individuals.

PHE guidance on providing better care to individuals with co-occurring Mental Health, alcohol and drugs (COMHAD) operates on two core principles[47]:

- Everyone's responsibility: emphasising the joint responsibility of commissioners and providers to meet the needs of people with COMHAD through partnership working
- No wrong door: providers of drug, alcohol, mental health and other services have an open door policy to individuals with COMHAD

Evidence for treatment

The Public Health England Evidence review of the outcomes that can be expected of substance misuse treatment in England summarises international evidence, outlining the outcomes that can be reasonably expected from drug treatment. It also summarises harms reduced by treatment and highlights domains that should be used to assess treatment effectiveness[94].

Opioid Substitution Therapy (OST) is the most extensively researched intervention, associated with:

- A 66% rate of abstinence from heroin
- A 77% retention rate in treatment
- Substantial reductions in injecting and sharing equipment (associated with 54% reduced risk of HIV, 64% reduced risk of hepatitis C)
- Significant reduction in fatal overdose risk
- Trusted by service-users in its ability to stabilise treatment and lead to wider supports

Psychosocial interventions have a mixed evidence base. Modalities with evidence of effectiveness include:

- Brief motivational interviews, designed to create self-motivated change, reduce use among opioid and stimulant users
- Contingency management (CM), based on behavioural positive reinforcement, helps cocaine and opioid users achieve abstinence (while receiving the intervention)
- Cognitive behavioural therapy (CBT), a skills-based approach to facilitate abstinence, is effective compared to no treatment, particularly for cocaine addiction

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[90] National Institute for Health and Care Excellence (NICE). *Drug misuse in over 16s: opioid detoxification* [Internet]. London: NICE; 2007. (Clinical guideline [NG52]) [cited 2026 Feb 25].
[91] National Institute for Health and Care Excellence (NICE). *Alcohol-use disorders: diagnosis, assessment and management of harmful drinking (high-risk drinking) and alcohol dependence* [Internet]. London: NICE; 2011. (Clinical guideline [CG115]) [cited 2026 Feb 25].
[92] National Institute for Health and Care Excellence (NICE). *Needle and syringe programmes* [Internet]. London: NICE; 2014. (Clinical guideline [PH52]) [cited 2026 Feb 25].
[93] Public Health England (PHE). *Substance misuse in people with learning disabilities: reasonable adjustments guidance*. London: PHE; 2016 May 8.
[94] Public Health England (PHE). *An evidence review of the outcomes that can be expected of drug misuse treatment in England*. London: PHE; 2017.

- Family/ couples intervention are effective to achieve abstinence from cocaine and heroin
- 12-step community programs (Alcoholics or Narcotics Anonymous) are also associated with abstinence, and reduced drug-related harms

Residential treatment is recommended for individuals with complex needs, or repeated community treatment failures. Continuing / aftercare is shown to improve sustained recovery outcomes.

Criminal Justice interventions have shown to contribute to improved treatment outcomes and crime reduction:

- Prison diversion initiatives (aimed to divert people who use drugs away from prison into treatment) effectively reduce drug use
- OST is a major driver to reduce offending, with improvements proportional to time in treatment
- Treatment reduces drug-related crime at a population level

Studies investigating the long-term effects of opioid treatment have demonstrated marked reductions in opiate use. Although only a minority achieve complete, long-term abstinence, treatment is associated with substantial functional improvements and harm reduction.

Appendix B: Full technical methodological detail

The following section provides the full technical details for the evidence and policy review, epidemiological, comparative and corporate analysis:

Rapid literature review search strategy.

The following search strings were used:

- Substance misuse ("drug misuse" OR "problem drug use" OR "alcohol misuse" etc)
- Adults ("Working age" OR "community" OR "residents")
- UK ("UK" OR "England" OR "London")
- Need/ unmet need/ service use ("Barriers to treatment" OR "service access" OR "service provision" etc)

Optional search terms included comorbidities such as "coexisting mental health" or "disability" and social contexts such as "inequalities", "homelessness", "inclusion health".

All searches were carried out on 10th October 2025. Titles and abstracts were screened by one reviewer and full texts were assessed against the following inclusion criteria:

- Population: adults over the age of 18 in high-income settings
- Exposure: problematic drug or alcohol use
- Comparator: NA
- Outcome: relating to coverage of treatment services, access to services, barriers to substance misuse treatment OR related to drug harms as a result of accessing/ not accessing treatment
- Study type: any original research, systematic or narrative review (NOT case studies, letters, non-peer reviewed)
- Publication date: within the last 10 years
- Language: English

The search retrieved 187 studies, which screened by title +/- abstract. After screening, 24 met the criteria for inclusion in the rapid review.

The most common cause for exclusion was for articles that were not set in high-income countries and articles about children and young people, rather than adults.

Rapid policy review search strategy

A structured search strategy was used to identify up-to-date, relevant national policies, guidelines, evidence summaries and statistical resources relating to adult substance misuse in England. Searches were conducted across Gov.UK, NHS England and NICE as well as reviewing publications from drug- and alcohol- associated policy institutions and voluntary organisations (such as the Institute for Alcohol studies).

Gov.UK was chosen as the primary database as it contains official UK government policy, legislation, national strategies, statistical releases and guidance relating to health and wellbeing, criminal justice, employment and housing. It contains documents published by key government departments and arms-length bodies including, but not limited to, DHSC, OHID, ACDM, PHE, Home Office.

One reviewer carried out screening by title and, where necessary, by description using the following inclusion criteria:

- Relating to England or England and one or all of the devolved nations
- Adult focus
- Consisted of guidelines, statistical pages, evidence summaries, policy documents
- Addressed substance misuse (alcohol and/ or illicit drugs)

Documents were excluded if they met any of the following criteria:

- Related solely to devolved nations, not to England
- Were out of date (i.e not the most recent version)
- Children and young people focus
- Concerned alcohol sales (rather than health need)
- Calls for evidence (rather than evidence sources)
- Related to acute or inpatient care
- Related to specific pharmacological management/ prescribing guidelines

The search strategy is detailed in the table below:

Data-base	Date	Search terms	Filters	Inclusion	Exclusion	Results	Included
Gov.uk	13/8 2025	"Alcohol" "Drug" "Substance misuse" "cocaine" "cannabis" "opiates" "COMHAD" "co-occurring mental health alcohol and drugs"	Topic: any Type: policy papers and consultations, guidance and regulation, research and statistics, policy papers and consultations Updated after: 2020	England +/- devolved nations Adults Guidelines, statistical pages, evidence summary, policy	Solely devolved nations/ international Out of date CYP Guidance on alcohol sales Calls for evidence Relating to IP care	2,079 101/ 209 pages screened	45
Gov.uk	9/9 2025	As above	As above except updated after 2015, before 2020	As above	As above	533	11
England.nhs.uk	22/9 2025	"alcohol"	N/a			197	4
England.nhs.uk	22/9 2025	"substance misuse"	N/a			101	1
NICE	24/9/25	"Alcohol", "substance misuse", "dependence"	Guidance and care quality standards			80+297	10

Epidemiological

Data analysis

Analysis of the data, including graphs, was carried out using excel. Maps were created with QGIS 3.40. Where raw numbers were compared across areas, population-adjusted rates were calculated using mid-year population estimates (ONS). Hospital admissions and mortality rates are provided as age-standardised rates as calculated by OHID.

When looking at trends, a timeframe of five years was used. However, the COVID-19 pandemic often had a significant effect on data therefore the five-year pre-COVID baseline was considered, but the overall trend was analysed post-COVID.

Inequalities in access to treatment services were analysed by calculating treatment penetration; demographics of the treatment population was compared with population demographics. Treatment penetration was compared across Bexley, London and England.

Data on harms (hospital admissions and mortality) were stratified by sex. Nationally, these data are available stratified by IMD decile. Treatment data were stratified by substance used, age group and sex. NDTMS groups people who use drugs and alcohol into different groups depending on the primary substances that they receive treatment for: opiates only, crack (no opiates), opiates and crack, alcohol only, non-opiates and alcohol, non-opiates only (excludes crack). Prevalence estimates are reported for OCU (opiates and/ or crack use).

Comparative

Where possible, figures were compared with Bexley's nearest neighbours – which include the Southeast London boroughs of Bromley, Greenwich, Lambeth, Lewisham and Southwark – to provide a meaningful local benchmark within our regional context. Comparisons with Bromley were made as a statistical neighbour with similar demographics (therefore would expect similar outcomes). Where comparison at this level was not possible due to data availability or the resource requirements of extracting multiple borough-level datasets, the local picture in Bexley is benchmarked against London and England, ensuring the local picture in Bexley can still be interpreted against wider trends.

Service evaluation

A full service evaluation, including cost-effectiveness, was out of scope of this needs assessment. Provision of services by Pier Road was assessed against the recommendations set out by the orange book.

Corporate

Stakeholder engagement/insights

To contextualise epidemiological findings, stakeholder insights were collected via semi-structured interviews with representatives from the council, NHS and third sector organisations including:

- Local substance misuse service, Pier Road Project (PRP)
- Adult Social Care
- Oxleas NHS foundation trust
- Inpatient psychiatric liaison, Lewisham and Greenwich NHS Trust
- Met Police
- Bexley Safeguarding Adults Board
- Southeast London ICS
- General Practice
- Bexley rough sleeping team
- Bexley Community Safety Services
- Thames Reach
- Bexley domestic abuse services
- Solace
- Bexley family hub
- DWP
- Bexley Voluntary Service Council (BVSC)
- MIND
- Bexley CDP

Interview questions were designed in consultation with the needs assessment working group and aligned with the research questions of the needs assessment. Where relevant, data from the epidemiological analysis or literature review were presented to stakeholders to explore how evidence aligned with experiences of service delivery.

Interviews particularly aimed to understand how services highlight individuals with substance misuse, staff confidence addressing substance misuse and awareness of available support. This enabled exploration of how routine contacts support early identification and intervention for individuals with substance misuse. Interviews with service providers also allowed service mapping of the treatment and recovery system. The primary researcher also attended CDP meetings and meetings for criminal justice, mental health, and children and young peoples CDP subgroups.

Analysis of stakeholder interviews was carried out by summarising key themes.

Service User Feedback

In order to gain insight into the experiences of service users, the primary researcher attended two relapse prevention groups at the Pier Road Project and conducted semi-structured interviews with attendees. Interviews took place in a group setting during the session and followed a question guide developed in consultation with the needs assessment steering group. Questions explored experiences of accessing support, barriers to treatment, perceptions of PRP and views on what would make treatment and recovery journeys easier.

The participants were adults currently engaged in structured treatment or relapse-prevention support at PRP. Attendance was voluntary, and individuals were informed verbally that insights would be anonymised and would inform the needs assessment. The purpose and scope of the needs assessment was verbally explained to participants.

Interviews were not audio-recorded and notes were taken manually in order to maintain comfort and openness. Analysis of interview data was by summary of key themes.

GP survey

A survey of GPs in Bexley was conducted with the aim of understanding confidence addressing alcohol and drug use among patients, knowledge of support services, barriers for patients accepting support and referral practices.

The survey was designed in consultation with the steering group, with questions informed by findings from stakeholder interviews and the data review. The survey was piloted with two GPs working in Bexley and subsequently distributed via social media (GP network WhatsApp groups) and by email to the local care network and to the GP trainee network.

Analysis of survey responses were carried out by excel.

Limitations

Data limitations

Prevalence of drug use

There is no local data source that measures the prevalence of specific drugs or alcohol use among the general adult population in Bexley. Local estimates for alcohol dependence and opiate and/ or crack use (OCU) exist, but these are modelled using national data-matching methods, which are limited by incomplete matching (e.g. inaccuracies in personal details) and by the absence of many individuals from the datasets used (mortality, criminal justice and treatment records). For all other substances, population-level estimates are only available through the Crime Survey for England and Wales, which provides national self-reported data. While useful for understanding broad national trends, these surveys are subject to underreporting and recall bias and cannot be reliably applied to the local population. As a result, understanding of drug use outside treatment services relies on accurate identification and recording by wider services when it is relevant to care.

Mortality data and hospital admissions

Mortality data and hospital admission data both rely on either clinicians or coroners attributing the cause of death or admission to drugs or alcohol. In cases where substance use contributes to, but is not recorded as the primary cause of, an admission or death – such as trauma that occurred during intoxication – these harms are not captured. Looking at drug poisoning by specific substances, in 2023, 22.9% of registered deaths had no drug recorded on the death certificate and most deaths involve mixed overdoses, making it difficult to determine primary substances. This contributes to an underestimation of drug- and alcohol-related harms.

The number of alcohol- and drug-related deaths in Bexley is small, limiting the ability to identify meaningful trends or explore inequalities by demographic groups. Interpretation therefore relies on regional and national patterns. Additionally, drug-misuse mortality data are subject to long delays because cases require an inquest, resulting in a substantial reporting lag.

Treatment penetration

When calculating treatment penetration, population demographics are taken from the 2021 census, which is now five years old, while treatment data are from 2025.

Treatment data

Stakeholders highlighted instances of incomplete data matching which may limit accuracy of continuity of care data between the probation and treatment services. Police and treatment services have a data matching system although there are still incidents of incomplete data matching.

Qualitative data limitations

Stakeholder interviews were conducted with representatives from a range of service providers. However, only a small number of individuals were interviewed from each organisation; most were those already engaged with the CDP. This may limit representativeness of the findings, both because of the small sample size and because individuals closely involved in the CDP may have higher levels of knowledge, confidence and engagement with substance misuse issues than the wider workforce. As a result, the insights obtained may present a more optimistic view of awareness and practice than is typical across staff.

The survey of GPs did not receive any responses following its distribution, despite reminders. Therefore, results of a second survey, conducted February 2025, were included. This survey was not designed in discussion with the steering group or piloted among a small number of GPs. It was distributed via the same channels. Questions were multiple choice. For questions relating to barriers and facilitators, respondents were required to select at least one option from a “select all that apply” list, and no “none of the above” option was provided. As a result, it is possible that some GPs selected an option that did not fully apply in order to progress to the next question. Findings should be interpreted in the context of these limitations.

Service user feedback was only sought from a small number (eleven) individuals who were further along in their treatment journey, which limits representativeness of the findings. This may be a self-selecting population who are more likely to be positive about the services provided. In addition, feedback was provided in the presence of a PRP recovery worker, which may have discouraged service users to offer views on how services might be improved.

Appendix C: Breakdown of disabilities in treatment

Disability status of individuals in treatment by disability type

	Behaviour n (%)	Hearing n (%)	Manual n (%)	Learning n (%)	Mobility n (%)	Perception n (%)	Personal n (%)
Bexley	388 (95.1)	5 (1.2)	5 (1.2)	24 (5.9)	21 (5.1)	1 (0.2)	6 (1.5)
London	3,620 (50.4)	232 (3.2)	153 (2.1)	988 (13.8)	1,543 (21.5)	70 (1.0)	169 (2.4)
England	30,181 (53.9)	1,651 (2.9)	1,063 (1.9)	6,343 (11.3)	11,546 (20.6)	306 (0.5)	907 (1.6)

	Progressive n (%)	Sight n (%)	Speech n (%)	Other n (%)	Not stated	No disability n	Any disability n
Bexley	14 (3.4)	2 (0.5)	1 (0.2)	17 (4.2)	0	76	408
London	1,022 (14.2)	212 (3.0)	69 (1.0)	945 (13.2)	486 (6.8)	15,434	7,182
England	10,706 (19.1)	1,461 (2.6)	406 (0.7)	5,799 (10.4)	6,583 (11.8)	106,015	56,015

Source: OHID via NDTMS *Local Outcomes Framework (2025)*.

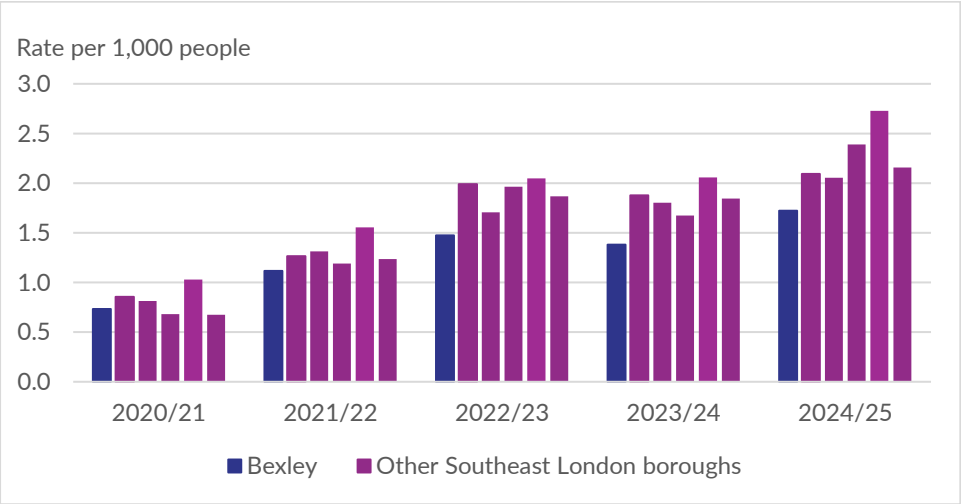
Appendix D: 111 calls for alcohol and drugs

Figure D shows a five-year rise in alcohol- and drug-related 111 calls across SEL boroughs. This may reflect greater reliance on 111 due to pressures on emergency and primary care. Bexley consistently records lower rates than neighbouring boroughs, with the gap widening in the past three years.

These data were excluded from the main report due to limitations, including low call numbers per quarter, meaning 111 contacts likely capture only a small proportion of acute drug- or alcohol-related incidents—most severe cases result in 999 calls instead. For 2023/24, only Q1 and Q4 data were available; values for Q2 and Q3 were estimated by doubling available figures and should therefore be interpreted with caution.

Figure D: rates alcohol- and drug-related 111 calls have risen over time in all Southeast London boroughs and are comparably low in Bexley.

111 calls relating to alcohol and drug misuse (rate per 100,000 people), in Bexley and SEL boroughs (grouped by borough of registered GP), 2020/21 – 2024/25



Source: Southeast London Integrated Care System *111 Triaged Calls Report Dashboard* 2020-2025, ONS mid-year population estimates 2020-2024.
Other SEL boroughs include Bromley, Greenwich, Lambeth, Lewisham, Southwark.
111 calls categorised as 'Drug, solvent, alcohol misuse' OR 'Alcohol intoxication' OR 'Ingestion, inhalation, overdose'

Appendix E: Alcohol- and drug-related LAS calls by age

Figure E: Alcohol- and drug-related ambulance calls become less common with age.

Alcohol- and drug-related ambulance calls (count) in SEL, 2023 and 2024.

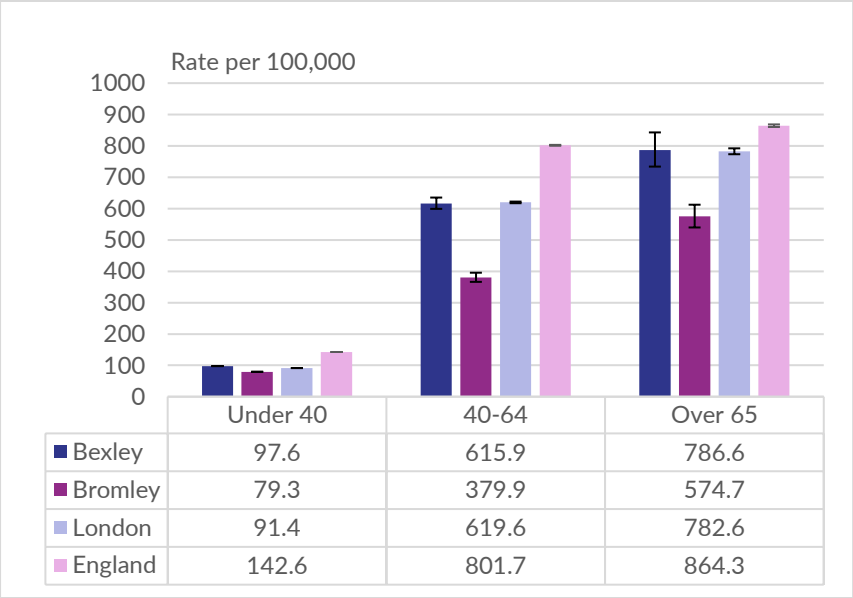
	Age group							
	16-20	21-30	31-40	41-50	51-60	61-70	71-80	81-90
Alcohol-related	997	2434	2821	2499	2142	1107	415	86
Drug-related	501	1379	1315	889	492	210	107	72

Source: alcohol- (where paramedic recorded as 'Alcohol-related') and drug- (where caller declared 'Class A related' or paramedic recorded as 'Overdose') LAS calls, Safestats, Greater London Authority, 2023 and 2024.

Appendix G: Alcohol-related hospital admissions by age.

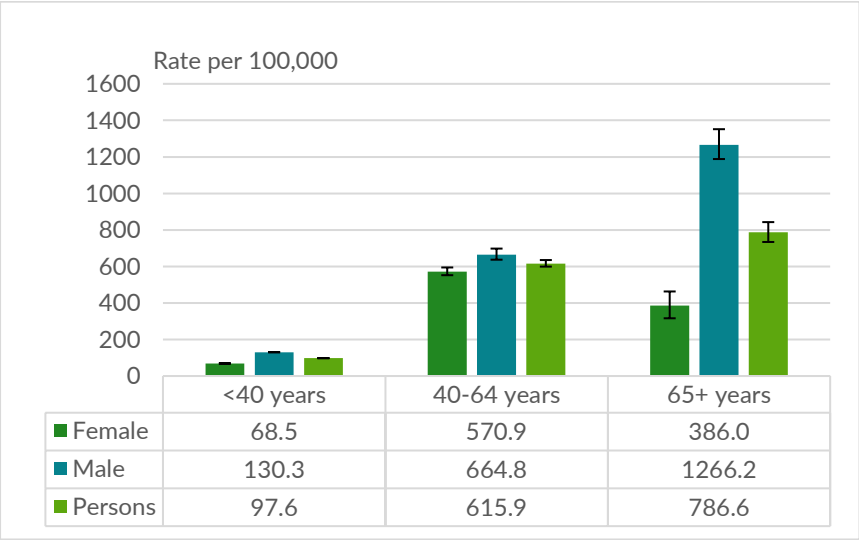
Figure G: Alcohol-related hospital admissions are more common among older adults and men.

a) Hospital admissions for alcohol-specific conditions (rate per 100,000 people) in Bexley, Bromley, London and England (2023-24)



	Under 40	40-64	Over 65
Bexley	97.6	615.9	786.6
Bromley	79.3	379.9	574.7
London	91.4	619.6	782.6
England	142.6	801.7	864.3

b) Hospital admissions for alcohol-specific conditions (rate per 100,000 people) in Bexley by age and gender (2023/24)



	<40 years	40-64 years	65+ years
Female	68.5	570.9	386.0
Male	130.3	664.8	1266.2
Persons	97.6	615.9	786.6

Source: OHID. *Fingertips: Public Health Profiles* (2025).

Appendix H: Referrals into PRP

Referral sources into local structured treatment services (Pier Road Practice).

Service source	Jan – Sep 2024	Jan – Sep 2025	Percentage change
Self-referral	418	411	-0.01%
CJS*	232	328	+41.4%
ASC	4	7	-
CSS**	33	46	+39.4%
Social Prescribers	5	1	-
GPs	79	88	+11.3%
Hospitals	53	60	+13.2%
Housing Officers	1	1	-
JobCentre	2	4	-
Mental Health Teams***	125	153	+22.4%
MIND Bexley	41	36	-12.2%
Drug and Alcohol services outside Bexley	25	17	-32.0%
Rose Bruford College	0	1	-
Solace	2	1	-
Thames Reach	8	6	-
Other	3	6	-
Total	1031	1166	+13%

Source: Pier Road Project

*CJS = prison, probation, required assessments via police, courts; **CSS = children social services including family wellbeing; ***Oxleas, home treatment team, Erith Centre.

Where referral numbers are small (less than ten), percentage change is not recorded.

Source: PRP

Appendix I: Narrative summary of stakeholder feedback

Narrative summary of stakeholder feedback:

Individuals using drugs and alcohol who are not engaged in treatment services

Insights highlighted a tension between normative definitions of need and individuals' perceived need. Across services, professionals reported that the most common barrier to accessing treatment was that adults did not perceive their substance use as problematic. This is particularly the case for referrals from the CJS where there is not a treatment order.

Stakeholders from ASC, MIND, community mental health services and OneBexley highlighted that older adults may represent a hidden population with unmet alcohol misuse needs.

Concerns raised by stakeholders included:

- Many older adults do not perceive their alcohol consumption as problematic or harmful, as it is often viewed as a long-standing habit.
- Family members are frequently the ones to report concerns about excessive alcohol use, putting isolated older adults at increased risk.
- Reliance on others to purchase alcohol has exposed older adults to financial abuse.

At the memory clinic, patients are asked routinely about their alcohol use, however to access this data would require an audit of patient notes. Often, this is the first time that a professional is bringing up their alcohol intake.

Early identification, prevention and harm reduction

Stakeholder feedback indicated that routine enquiry is inconsistent across services.

Stakeholders described gaps in workforce confidence around substance misuse, particularly around drugs. Although they described pockets of good practice across organisations, there is inconsistency across the workforce. Similarly, there is a lack of confidence delivering brief advice following disclosure of substance misuse. Some stakeholders felt that it was not part of their remit to deliver brief advice.

Across organisations, there was an appetite for training to strengthen workforce confidence. Many stakeholders were not aware of training sessions on substance misuse that are administered by Bexley SHIELD and the Adult Safeguarding Board.

Referrals into treatment

There was knowledge of the PRP across services, however gaps did exist:

- Stakeholders were not universally aware the PRP does not apply a severity threshold for referral.
- Although stakeholders recognised that best practice is to refer clients into treatment on their behalf or supervise a referral, teams often signpost clients to self-refer.
- Stakeholders expressed a desire for feedback on referrals, highlighting the need for a two-way communication process between referring services and treatment providers – for example for Mental Health services to provide feedback to Substance Misuse services, and vice versa.

Continuity of care from prisons

Stakeholders highlighted barriers to continuity of care from prisons:

- Early prison releases, which have increased in rate and pose barriers to the organisation of timely assessments and prescription/ dispensing of substance misuse medications

and awareness of wider support services to access on release (Salvation Army, St Giles, Housing and Employment Support).
- The hosting of Bexley residents across many prisons, making prison outreach challenging.
- Conflicting appointments on the day of release (housing, Jobcentre, probation) with distances to travel between each.
- Lack of forwarding details (phone number, address) to enable PRP to follow-up referrals.
- Limited awareness and visibility of the SEL Turning Point prison link worker role at HMP Thameside.
- Non-engagement from individuals who do not have a treatment court order.

They highlighted facilitators to continuity of care from prisons, including:

- Access to prisons to facilitate earlier engagement, timely prescribing of OST on release, and better coordination between the prisons and community services.
- Strong partnership working between PRP and probation services.
- Training of probation staff to deliver relapse prevention, to enable its delivery during regular contact with individuals who are not mandated by court order to attend PRP.

Barriers to accessing treatment

The most common barrier to accessing treatment was a perception that substance misuse was not problematic. However, stakeholders identified further circumstantial barriers.

Among parents with substance misuse, stakeholders described fears of having children removed from their care and practical challenges such as leaving home to attend treatment, particularly where parents may have coexisting anxiety or mental health. The Family Wellbeing unit was thought to be associated with less anxiety of child removal as a first point of contact for family support.

Stakeholders identified barriers to presenting to treatment for minority ethnic groups, describing instances where individuals had delayed presenting to treatment services due to stigma from their own ethnic, cultural or religious community. This was particularly the case when accessing group treatments, due to fear of confidentially. Language can be a barrier, predominantly of knowledge of how to access treatment services and their role, as PRP does offer a translation service. This echoes findings from national research of drug-use in minority ethnic groups(cite).

Substance misuse services

Stakeholders reported satisfaction with the services provided by PRP, highlighting its inclusivity and its culture of 'second chances', reflected in practices such as rebooking missed appointments, proactive engagement with individuals, and welcoming clients back to treatment following unplanned exits.

However, feedback highlighted two potential gaps in service accessibility:

- Geographical gap: PRP is located in Erith in the North of the borough, which limits accessibility for individuals in the South of the borough.
- Access for Full-time employed: PRP offers extended hours to accommodate individuals in full-time employment, but group treatments are scheduled during daytime hours. This limits access to the full range of services for those who work regular hours and may reduce treatment options for this cohort.

COMHAD

National guidance promotes a 'no wrong door' approach ensuring individuals with COMHAD can access support in Mental Health and substance misuse settings. Local policy requires Oxleas Mental Health Services to assess all service users regardless of substance use and provide appropriate signposting or treatment 'irrespective of any opinion about cause and effect of their substance use on their mental health' (Oxleas COMHAD policy 5.0 provision of services).

Despite this, stakeholders reported ongoing barriers to mental health care for people with substance misuse. MIND does not treat clients with substance misuse, but barriers were also noted among Oxleas services. A referral should be declined if substance misuse is the sole diagnosis, but stakeholders described barriers arising if individuals are not assessed or the drivers of substance misuse are not thoroughly explored.

Stakeholders reported strong partnership working between mental health and substance misuse services, noting that this relationship has strengthened over time. Partnership working is supported by the CDP mental health subgroup and strong clinical links, where doctors rotate across both Trusts. Weekly COMHAD meetings to discuss joint cases between Oxleas and PRP facilitate care coordination.

IT systems remain a barrier to integrated care; MIND, Oxleas and PRP operate different systems that are not accessible across organisations. While substance misuse notes are visible on the London Care Network, mental health notes are not. Although continuity of care is facilitated by a data-sharing agreement between MIND, Oxleas and PRP, this requires a request for information to be made and responded to.

In the acute hospital setting, stakeholders reported that securing inpatient admission for individuals with co-occurring severe mental health needs and substance misuse can be more challenging than for those without substance misuse. This difficulty is compounded for people experiencing homelessness.

Housing

Housing was consistently identified by substance misuse, mental health and wider service providers as one of the most significant barriers to care. Challenges highlighted include:

- Lack of stable housing prevents services from maintaining contact, as outreach and follow-up are challenging without fixed addresses or phone numbers. In other boroughs, hostels provide a point of contact for outreach, but this provision is absent locally.
- The rough sleeping team can advocate for individuals and support attendance at appointments but stakeholders highlighted barriers when transitioning from specialist services (for example the RAMP mental health team) to mainstream care. This increases the risk of disengagement after securing housing.
- Rehabilitation services cannot accept individuals who are unhoused.
- The housing stock in Bexley is limited; stakeholders gave examples of individuals placed in privately owned Houses of Multiple Occupancy (HMOs) which were inappropriate for vulnerable individuals, contributing to risks of relapse, reoffending and exploitation.
- Individuals experiencing homelessness face benefit sanctions due to conflicting appointment requirements, although examples of good partnership working with the Jobcentre to mitigate this risk were described by stakeholders.

Despite challenges, stakeholders highlighted positive examples of advocacy and support for individuals experiencing homelessness and substance misuse at PRP, Bexley Rough Sleeping team and third sector organisations including Thames Reach, St Giles, ReState and Salvation army. Examples include:

- Coordination of outreach work between Thames Reach and PRP to provide substance misuse initial assessments.
- Continual active engagement between PRP and Rough Sleeping team
- Availability of OST depot injections at PRP, enabling stabilisation without daily pharmacy visits for supervised consumption.
- Salvation army Community Homeless Drop-In offering a warm welcome space and access to support services weekly.

Outside of the rough sleeping team, engagement between housing officers and PRP was reported to be limited, reflected in low numbers of referrals into treatment.

Employment

As outlined in 5.9 Employment, Universal Credit conditionality can be paused for individuals who disclose substance misuse. Identification of substance misuse at the Jobcentre relies on self-disclosure to work coaches, which then triggers conditionality changes, signposting to treatment services, and recording of additional customer support needs on the system.

However, stakeholders identified barriers in this process:

- Jobcentre is not perceived as a trusted environment, which limits disclosure. As a result, substance misuse often emerges only during appeals following sanctions, leaving individuals without Universal Credit for a period. This aligns with national data showing that 86% of sanctions are overturned at mandatory reconsideration.
- Inconsistent engagement among staff with wider services to facilitate lifting conditionalities. Stakeholders noted that specific individuals make this process easier, but this is not consistent across the workforce.
- Referral practice: work coaches typically signpost individuals to self-refer rather than making direct referrals to treatment services.
- Lack of workforce confidence addressing substance misuse.
- Limited engagement between substance misuse services and employment support. Operational leads exist in the Greenwich and Bexley DWP partnership to strengthen links with statutory agencies but there is scope to improve coordination with substance misuse services.
- Loss of a dedicated substance misuse lead: previously, Greenwich and Bexley DWP had a designated substance misuse lead to support work coaches, but this role is no longer in place. Stakeholders pointed to support for care leavers as an example of good practice, where strong collaboration with the care leaving team is facilitated by a dedicated lead.

Adult Social Care

Through the continuing efforts of the CDP CYP subgroup there has been an increase in parental referrals into treatment from Children's Social Care (including the Bexley Family Wellbeing Service). Stakeholders highlighted a gap in awareness of the role of the PRP and confidence addressing substance misuse among ASC, for example referring individuals back to the GP rather than directing them towards treatment services.

Partnership working

Across systems, stakeholders described strong partnership working, highlighting:

- CDP subgroups: facilitated by commissioner involvement, strengthened substance misuse, criminal justice, mental health and children and young people's professional networks have supported workforce development to increase awareness of substance misuse, harm minimisation and referrals into treatment.
- Consistent engagement between substance misuse services and rough sleeping teams.
- Multi-agency Risk Assessment Conferences (MARACs), enabling care coordination for complex cases under multiple services.

Across services, stakeholders expressed a desire for bidirectional communication, particularly the ability to receive timely feedback on the progress and outcome of referrals.

Stakeholders expressed interest in PRP delivering outreach within their service. However, this is infeasible across organisations owing to significant resources requirements. Instead, an emphasis should be placed on bolstering provision and promoting awareness of training opportunities. Building on the success of professional networks – such as those established through CDP subgroups – and increasing awareness of PRP's professional advice service can help embed the principles of 'all of our health' and ensure substance misuse becomes a shared priority across the system.

GP

Stakeholders reported generally good engagement between GPs and wider services, though some inconsistencies were noted. GPs located in the north of the borough, closer to PRP, were perceived to have stronger partnership working with substance misuse services. The Albion Surgery in Bexleyheath was specifically highlighted by the rough sleeping team as responsive and helpful in providing medical summaries and information.

However, concerns were raised regarding variability in the standard of care. Some stakeholders observed that individuals appeared to receive different treatment depending on whether an advocate from another service was present. For example, following transition from specialist rough sleeping support to mainstream services, individuals without advocacy were perceived to experience barriers to receiving primary care.